Arizona Medical Board

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FINAL MINUTES FOR REGULAR SESSION MEETING
Held at 9:30 a.m. on February 8, 2006, and 8:00 a.m. on February 9, 2006
9535 E. Doubletree Ranch Road · Scottsdale, Arizona

Board Members

Tim B. Hunter, M.D., Chair
William R. Martin III, M.D., Vice Chair
Douglas D. Lee, M.D., Secretary
Patrick N. Connell, M.D.
Ronnie R. Cox, Ph.D.
Robert P. Goldfarb, M.D.
Becky Jordan
Ram R. Krishna, M.D.
Lorraine L. Mackstaller, M.D.
Sharon B. Megdal, Ph.D.
Dona Pardo, Ph.D., R.N.
Paul M. Petelin Sr., M.D.

WEDNESDAY, FEBRUARY 8, 2006

CALL TO ORDER

Tim B. Hunter, M.D. called the meeting to Order at 9:30 a.m.

ROLL CALL

The following Board Members were present: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D, Paul M. Petelin, M.D. The following Board Member was absent: Robert P. Goldfarb, M.D.

Executive Director's Report

Legislative Update

Mr. Timothy Miller, J.D., Executive Director provided two legislative update memos to the Board. The first memo was for all general current legislative matters. The second memo extracted Bills from the first memo that either would affect the Arizona Medical Board directly or the practice of medicine in general. Mr. Miller summarized the Bills on the second memorandum.

House Bill (HB) 2657- This Bill would allow lay midwifes, not just nurse midwifes, to prescribe certain non-controlled medications and medical devices. Mr. Miller said the lay midwifes have no formal medical training, but rather have to attend a certain number of births to become qualified. Christine Cassetta, Legal Counsel read the specific wording of the Bill and commented that the Bill insinuated additional duties would be allowed as a result of the medical devices they would be given the authority to obtain, including repair of lacerations, resuscitations and administering of IV's, and prenatal and post-op care.

House Bill 1084- This is the Arizona Medical Board Omnibus Bill allowing the Board to issue non-disciplinary CME, allow the Board to order physicians to pay for their own psychiatric and other evaluations, consistent with the Board's authority for MAP related evaluations. Mr. Miller said the Bill also removes the word "IV" from "IV sedation", and identifies those duties delegated to the Executive Director that may be appealed. Christine Cassetta, Legal Counsel said this Bill does not change the duties that are delegated to the Executive Director, but rather clarifies, constitute with the original intent, which duties are appealable.

Senate Bill (SB) 1102 – This Bill would eliminate an open investigation as a matter of public record. Mr. Miller said he believes the public becomes misinformed when they rely on information that a physician has an open investigation and interpret that to mean the physician has practiced below the standard of care. Mr. Miller said that approximately 80-85% of open investigations are dismissed, showing the

physician did not deviate from the standard of care. He said an educated consumer could make a bad decision due to misleading information.

Ram R. Krishna, M.D. said a reported open investigation does significantly affect the licensee. Tim B. Hunter, M.D. said the Board has discussed this before and he agrees providing the number of open investigations is inflammatory to the physician and does not provide substantial information to the public. Christine Cassetta, Legal Counsel commented that an open investigation on a profile may cause a consumer to choose another physician when the physician with the open investigation is really the best physician for the consumer.

The Board members unanimously agreed to support this bill.

Senate Bill 1383- This Bill requires the Pharmacy Board to create a database for tracking narcotics, the DHHS has made 1.1 million dollars available for implementation of the system. The system would allow doctors and pharmacists to inquire whether patients are seeking drugs. It would also allow for Boards to query for a pharmacy survey rather than contacting each pharmacy individually.

Tim B. Hunter, M.D. suggested a system be in place to ensure the database is not be abused and used unprofessionally for curiosity purposes to check on people who are not patients of a physician. Ms. Cassetta said an idea may be to implement authority to consider misuse of the system unprofessional conduct.

Patrick N. Connell, M.D. said it would be a great service to an Emergency Room physician to help determine which patients are drug-seeking.

Senate Bill 1492- This Bill would allow appropriation for the student loan program ending the sweep of Arizona Medical Board fund.

House Bill 2240- This Bill limits the amount a board may charge for licensing to a percentage over previous years. Becky Jordan spoke against the revenue limitation bill as the Arizona Medical Board could have a surge in physician population growth and it may not be timely to reduce fees if the Board may have to regulate more physicians. Mr. Miller said most of these bills are still in their infancy stages.

House Bill 2254- This Bill deals with notification of fetal pain. The Board declined to take a position or comment on the fetal pain Bill.

House Bill 2426- This Bill makes it an act of unprofessional conduct for a physician to require a lab to bill the physician rather than billing the payer directly.

House Bill- 2681 – This Bill would require physicians to obtain informed consent from a patient before harvesting donated eggs.

House Bill 2716- This Bill pertained to judicially appointed health professionals. He said the Board does not have a problem of this nature and suggests the Board not take a position on this matter.

House Bill 2786- This Bill would require the Arizona Medical Board to retrieve, store and distribute medical records abandoned by physicians. However, there would be no compensation to the Arizona Medical Board for this service. Dr. Lee said the Board is not in favor of physicians abandoning their medical records and finds it an act of unprofessional conduct. However, he said it is not the Board's responsibility to assume distribution of medical records once they are abandoned.

Agency Division Update

Mr. Timothy Miller, J.D., Executive Director recognized the tremendous job by Staff in closing 2,700 cases in one year either by dismissal or by bringing the matter to the Board. Mr. Miller said the agency currently has 756 cases open and has reduced the number of cases by 184 cases since December 2005. Mr. Miller said there are currently eleven 2004 cases open, some of which are on this Board Meeting's Agenda. Mr. Miller said the agency's on-going goal is to only have cases open from the previous year, consistently. Patrick N. Connell, M.D. asked when a case is marked as "complete". Mr. Miller said a case is complete when the investigation finished.

Mr. Miller also commented that the Arizona Medical Board's staffing levels have remained stable and morale has remained high.

Mr. Miller said the AMB Staff is still pushing ahead to implement the Physician's Health Program. Mr. Miller said he has spoken to the medical community and the program has been received warmly. Mr. Miller said he has had the opportunity to explain to professionals what is required to report a physician and how important it is to answer the questions of professional conduct on the license application correctly. Dr. Hunter suggested the Arizona Medical Board review the license application questions to ensure they are very black and white and also include a sheet of examples with the application regarding what needs to be reported.

Mr. Miller recognized the Information Technology Staff and gave them credit for keeping the Staff morale high by implementing amazing systems within the office.

Mr. Miller also said the AMB is performing a lot of work in the community, in various volunteering ways. He said the Licensing Manager will be helping to teach residents about the application process and Mr. Miller said he has approached a couple of residency programs about having the residents attending the Board Meetings. He said that overall the agency is building a good image in community and is now being called to provide assistance to various organizations.

Special Presentation

The Arizona Medical Board Members presented a plaque of appreciation to Ronnie R. Cox, Ph.D. for his years of service on the Board. Dr. Cox said it had been his pleasure to serve the Board for his appointed term.

Evaluation of Executive Director and Compensation Review

The Board went into Executive Session at 6:10 p.m. for a personal matter and for legal advice.
The Board returned to Open Session at 6:45 p.m.

Tim B. Hunter, M.D., Board Chairman said he is very thankful with the direction the Arizona Medical Board is going under the leadership of Mr. Timothy Miller, J.D., Executive Director. Dr. Hunter said Mr. Miller is doing an excellent job and has an excellent staff with high morale. Dr. Hunter said he has watched the considerable growth within the agency under Mr. Miller's leadership.

Ram R. Krishna, M.D. said Mr. Miller has chosen an excellent staff to help him bring the agency to the place it is today. Dr. Krishna said he could not single out any one Staff member because all have done an amazing job.

MOTION: Ram R. Krishna, M.D. moved to approve the Executive Director's salary request as presented in the memorandum to the Board dated January 17, 2006.
SECONDED: Ronnie R. Cox, Ph.D.
VOTE: 10-yay, 0-nay, 0-abstain/recuse, 2-absent
Motion Passed.

Approval of Minutes

Dona Pardo, Ph.D., R.N. provided staff with grammatical and typographical changes to the December 7-8, 2005 Regular Session Minutes including Executive Session Minutes. Ms. Cassetta also noted the Board discussed the list of reportable misdemeanors at the December meeting, but that discussion was not reflected in the minutes. Ms. Cassetta clarified the Board's intention was to use the list as prepared and presented to them in December.

MOTION: Ram R. Krishna, M.D. moved to accept corrected minutes with an edit including the discussion of the list of misdemeanors.
SECONDED: Douglas D. Lee, M.D.

Edit Minutes according to list of misdemeanors as discussed by the Board.

VOTE: 12-yay, 0-nay, 0-abstain/recuse, 1-absent

ADVISORY LETTERS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-03-0014A	AMB	ZEV FAINSILBER, M.D.	22634	Interim Order for a Psychosexual Evaluation to be paid for by the physician.

Patrick N. Connell, M.D. pulled this case for discussion. He said it was concerning that a complaint had been made of sexual misconduct, but he found there was not enough evidence to prove the allegation. Dr. Connell thought a psychosexual evaluation of the physician may assist the Board is determining if there are areas concern regarding this practitioner.

Mark Nanney, M.D., Chief Medical Consultant said the Arizona Medical Board Staff received the allegation from an insurance company. However, the insurance company refused to cooperate with the Arizona Medical Board's investigation.

Sharon B. Megdal, Ph.D. noted this case went directly to Formal Hearing per the physician's request and the States' Motion was to rescind referral to formal hearing and issue an Advisory Letter. However, Dr. Megdal noted the allegations supported by the State seemed different from the concerns the Board was discussing.

Stephen Wolf, Assistant Attorney General said that during the investigative interview with the patient it was found there was not enough evidence to sustain the allegation of unprofessional conduct. He said there was also an allegation of an unprofessional phone call made after the appointment. The physician does not deny the phone call, but said the call was to discuss the patient's test results, although he did not document the phone call in the medical record. Victoria Kamm, Senior Medical Investigator said the complainant did not have a clear recollection of the incident surrounding her allegations because it had occurred several years prior, and was hesitant to be definitive with her allegations during the investigative interview. The complainant said she had submitted a tape recording of an unprofessional phone conversation that occurred the same day of her appointment in the year 2003. However, the Board's previous staff did not preserve the phone conversation so that it would be available to new AMB staff that would be completing the investigation.

Dr. Megdal said that whether or not the alleged unprofessional phone call is documented does not excuse the underlying compliant of sexual misconduct during the patient's exam.

Dr. Connell said it is unfortunate that the events in this case occurred approximately three years ago and the details of this case will not be able to be re-obtained, he also found there was not enough evidence in this case to support any of the unprofessional conduct allegations. Dr. Connell suggested the Board order a psychosexual evaluation to see if there is some underlying issue in the physician's behavior.

Christine Cassetta, Legal Counsel advised the Board they could chose to continue the matter and issue an Interim Order for psychosexual evaluation, and reconsider the matter after the evaluation was complete.

MOTION: Sharon B. Megdal, Ph.D. moved to issue an Advisory Letter for possible boundary issues and failure to document a phone call made to the patient.
SECONDED: Lorraine Mackstaller, M.D.

Ram R. Krishna, M.D. spoke against the motion because he said boundary issues could not be proven.

Lorraine Mackstaller, M.D. spoke in support of the motion so that if a similar complaint occurred in the future, the Board would be able to track a pattern.

William R. Martin, III, M.D. spoke in favor of the motion saying if the Board could obtain some evidence of concern from a psychosexual evaluation, they could provide detail that would be more beneficial for the public. Likewise, if no negative information was obtained, those findings would in turn also benefit the public and the physician.

VOTE: 3-yay, 8-nay, 0-abstain/recuse, 1-absent
Motion Failed.

MOTION: Robert P. Goldfarb, M.D. moved to issue an Interim Order for a Psychosexual Evaluation to be paid for by the physician.
SECONDED: Patrick N. Connell, M.D.

Dona Pardo, R.N., Ph.D. asked the Ms. Cassetta her opinion as to whether the evidence in this case supported a psychosocial evaluation. Ms. Cassetta said there was enough evidence to support the motion.

Sharon B. Megdal, Ph.D. noted the allegation was made three years ago and the Board has not received any further allegations since. Tim B. Hunter, M.D. said he felt that ordering a psychosexual evaluation is detrimental to a person's reputation regardless of the results. Dr. Connell said the evaluation could be helpful to the doctor even if there is no underlying problem, because it could help him learn how to keep him from being perceived as unprofessional by his patients.

VOTE: 9-yay, 1-nay, 1-abstain 0-recuse, 1-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-04-0959B	AMB	IRENE S. DUARTE, M.D.	21997	Advisory Letter for failure to recognize breast cancer and order proper follow up.
3.	MD-05-0928A	J.G.	JAMES B. ROSS, M.D.	9584	Advisory Letter for an inadequate breast examination
4.	MD-05-0018A	AMB	ROBERT A. MILESKI, M.D.	24451	Advisory Letter for failure to identify and preserve the axillary nerve. This was a minor technical deviation.

Dr. Mileski was present and spoke during the call to the public. Dr. Mileski said he did not believe this case warranted an Advisory Letter because he felt he took the appropriate steps to protect the location of axilllary nerve while performing surgery for the patient. Dr. Mileski said the injured nerve was in such a remote location of where the axillary nerve usually resides, he felt it was possibly a branch of the axillary nerve. Dr. Mileski showed the Board a diagram to explain where the harm was done during the procedure. Dr. Mileski said he palpated for the nerve in the appropriate location and was watching for it. He concluded the injured nerve could not be the axillary nerve because it was so far removed from the location of the axillary nerve.

Lorraine Mackstaller, M.D. pulled this case for discussion and commented she was not sure the physician deviated in this case. Ram R. Krishna, M.D. said he wondered if the patient possibly experienced difficulties in the axillary nerve due to the patient's previous complications prior to seeing Dr. Mileski.

Gerald Moczynski, M.D., Medical Consultant summarized the case for the Board and noted Dr. Mileski's exam of the patient prior to surgery documented that the patient was neurologically in tact. Dr. Moczynski said the physician's post-op care was excellent, and he referred the patient to another surgeon when patient did not fully recover. The new surgeon discovered a suture had been placed around the axillary nerve. Dr. Moczynski noted Dr. Mileski's written response to the Board agreed it was the axillary nerve that was injured although in testimony before the Board at the Board Meeting, Dr. Mileski said he did not agree it was the axillary nerve that was damaged.

MOTION: Patrick N. Connell, M.D. moved to issue an Advisory Letter for failure to identify and preserve the axillary nerve. This was a minor technical deviation.
SECONDED: Ram R. Krishna, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-05-0205A	B.J.	MURALI D. TALLURI, M.D.	19237	Advisory Letter for signing blank, undated prescriptions.
6.	MD-05-0927A	C.S.	MARK D. FETTER, M.D.	24439	Dismissed.

This case was pulled for discussion. Robert P. Goldfarb, M.D. noted the allegation was that the physician left a sponge in the patient following an operation. However, the nurse assisting in the procedure gave the physician the proper sponge count after removal and the physician had no reason to believe any sponges remained in the patient.

Paul M. Petelin, M.D. noted the physician has since changed his protocol to use larger sponges that will not be easily missed.

MOTION: Ram R. Krishna, M.D. moved to Dismiss the case.
SECONDED: Lorraine Mackstaller, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

MOTION: Dona Pardo, R.N., Ph.D. moved to refer this case to the Arizona State Board of Nursing.
SECONDED: Ram R. Krishna, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
7.	MD-05-0913A	AMB	PETER C. KUCHARSKI, M.D.	28942	Offer a consent agreement for a Letter of Reprimand for failure to note a widened mediastinum on x-ray. If he does not accept the consent agreement, invite the physician for a formal interview.

Becky Jordan pulled this case for discussion saying the physician had no prior board history, but did have two malpractice cases.

MOTION: Paul M. Petelin, M.D. moved to offer the physician a Consent Agreement for Letter of Reprimand for failure to note a widened mediastinum on x-ray. If he does not accept the consent agreement, invite the physician for formal interview.
SECONDED: Patrick N. Connell, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
8.	MD-05-0418A	AMB	JOSEPH D. GIBEAULT, M.D.	13121	Advisory Letter for failure to protect the ulnar nerve during surgery.

Tim B. Hunter, M.D. recused himself from the case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
9.	MD-04-0991A	R.M.	MILUSE VITKOVA, M.D.	20176	Invite the physician for a Formal Interview.

R.M. was present and spoke during the Call to the Public regarding his wife, G.M. He said the company he wrote a check to for Dr. Vitkova to conduct an autopsy is not a legitimate company and was never licensed in the state of Arizona. He also said he told Dr. Vitkova exactly what he wanted her to look for in the autopsy. He said that because his wife had passed away following a shoulder operation and an attempt at intubation, he specifically asked she examine any findings from the shoulder operation, any possible damage to his wife's trachea due to the attempt at intubation, his wife's heart condition and finally to ascertain the cause of death. He said he first received an autopsy for a Caucasian male from Dr. Vitkova. Upon contacting Dr. Vitkova, she sent another autopsy that was again for a Caucasian male. Upon contacting Dr. Vitkova again to receive a correct autopsy, he received a report that said they removed G.M.'s brain and all other organs and weighed them. Both he and his daughters found this to be very traumatic and could not understand why this had been done. He said his daughter contacted Dr. Vitkova who said she had prepared the third autopsy from her notes. R.M. then contacted Dr. Vitkova to tell her she had not done what he requested for the autopsy and she replied in an adamant, and unfriendly manner that she had done a complete autopsy, she was through with her evaluation, and then she hung up the phone. R.M. said three weeks later he then received a check in the mail for $500.00 from Dr. Vitkova and a note that said "Sorry." R.M. said he said he paid $2,400 for the autopsy.

Lorraine Mackstaller, M.D. said she found the allegations in this case to be very distressing. Douglas D. Lee, M.D. said the doctor had received an Advisory Letter in 2004 for a similar complaint and he would like to see the physician come before the Board for a Formal Interview.

MOTION: William R. Martin, III, M.D. moved to invite the physician for a Formal Interview.
SECONDED: Lorraine Mackstaller, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
10.	MD-04-1125A	N.O.	MAGDA S. WILLIAMS, M.D.	26765	Dismissed

Jessica Olivarez, spoke during the call to the Public and said she has worked as a medical assistant for Dr. Williams for seven years. Ms. Olivarez said she feels the procedures for releasing medical records were followed by Dr. William's staff and nothing was done inappropriately.

Dr. Williams spoke during the call to the public. She said she was out of town during the day this case occurred and her staff told her the patient did not sign the release for medical records. Dr. Williams said she had her husband call the patient the day this occurred to apologize about any misunderstanding, and ask if the patient still needed the medical records. Dr. Williams said her relationship with this patient is still on good terms and the patient has since sent a letter to the Board stating she did not believe she signed an informed consent.

Dr. Joel Mascaro, D.O. was present and spoke during the call to the public on behalf of Dr. Williams. He said Dr. Williams strives to meet the needs of her patients and feels this case was a miscommunication issue between the patient and the staff of Dr. Williams.

MOTION: Becky Jordan moved to Dismiss the case.
SECONDED: Lorraine Mackstaller, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
11.	MD-04-1011A	AMB	THOMAS J. PETERS, M.D.	9582	Dismissed

Dona Pardo, R.N., Ph.D. pulled this case for discussion.

Gerald Moczynski, M.D., Medical Consultant summarized the case and said the FDA reported the case to the Arizona Medical Board. However, the material they sent to the Arizona Medical Board was so heavily redacted Staff could not tell why the case was reported. He did say, however, that the Staff could gather that all patients in the case did well with no ill effects, and the ceramic hip Dr. Peters used are no longer experimental, but are in use by other practitioners. He said the only deviation SIRC found was there was no informed consent provided for an experimental procedure.

Ram R. Krishna, M.D. noted that at the time Dr. Peters implanted the ceramic hip it was FDA approved. He also noted Dr. Peters was an approved medical investigator at the time the procedure was done.

MOTION: Ram R. Krishna, M.D. moved to Dismiss the case.
SECONDED: William R. Martin, III, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
12.	MD-04-0472A	AMB	JAGWINDER S. SRAOW, M.D.	13601	Dismissed

Ram R. Krishna, M.D. said he knows Dr. Sraow, but it will not affect his ability to adjudicate the case.

Paul M. Petelin, M.D. pulled this case for discussion. He said there was an allegation that there was failure to document that Dr. Lundell said the patient was not a candidate for further surgery and the risk would outweigh the benefit. However, Dr. Petelin said he did find documentation of this recommendation from Dr. Lundell.

Paul M. Petelin, M.D. said he said he found the physician took good care of patient and was the one who diagnosed the patient's aneurysm in first place.

MOTION: Paul M. Petelin, M.D. moved to Dismiss the case.
SECONDED: Ram R. Krishna, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
13.	MD-04-1418A	AMB	BRENT C. SANDERS, M.D.	6754	Advisory Letter for not sending the tissue to pathology.

Brent C. Sanders, M.D. and legal counsel, Ms. Kimberly A. Kent spoke during the call to public. Dr. Sanders said he understood the allegation in this case was his failure to send tissue to pathology. Dr. Sanders said because he had sent 20 polyps from the patient to pathology several weeks prior to the removal of the one tissue, he felt he had adequate pathology. It was Dr. Sanders' testimony that he believed sending additional polyps to pathology would not have changed his care for the patient since he felt he had enough evidence and had already made his diagnosis. Dr. Sanders said he now sends all tissue to pathology.

Ms. Kent, legal counsel said Dr. Sanders had an extensive pathology report for the patient and did not need further pathology. She also said that the incident occurred over seven years ago and there has been significant change in Dr. Sander's practice since then.

Becky Jordan pulled this case for discussion. This case had previously been block voted on by the Board for issuance of an Advisory Letter.

MOTION: Becky Jordan moved for the Board to reconsider their action.
SECONDED: Sharon B. Megdal, Ph.D.

VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
Motion Passed.

Robert P. Goldfarb, M.D. said that when removing tissue from the nose, one should not assume it is a polyp without sending the tissue to pathology. Dr. Goldfarb said that if the tissue removed is found to be an encephalocele it could create a cerebrospinal leak. Dr. Goldfarb also commented that although the patient did not report the leak until months after the tissue was removed, she could have been having clear drainage the entire time and not realized it until she had the motor vehicle accident that the leakage became more severe.

Patrick N. Connell, M.D. said he felt the issue was not necessarily that the physician caused the leak, but that he failed to send the tissue to pathology. Dr. Connell said he felt that anytime tissue is removed it should be sent to pathology.

MOTION: Patrick N. Connell, M.D. moved to issue an Advisory Letter for not sending the tissue to pathology.
SECONDED: Ram R. Krishna, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
14.	MD-04-1543B	C.C.	MICHAEL CAMPION, M.D.	16283	Invite the physician for a Formal Interview.

An Advisory Letter for implanting the wrong lens was issued by way of block vote. This case was pulled for discussion.

MOTION: Ram R. Krishna, M.D. moved to have the Board reconsider this case.
SECONDED: Lorraine Mackstaller, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

Mark Nanney, M.D., Chief Medical Consultant summarized the case for the Board. He said it is established that the wrong lens was implanted. He said he first understood the Outside Medical Consultant's report to say there was a clear deviation in this case. However, the physician contacted the Outside Medical Consultant who told him there was not a clear deviation in this case. Christine Cassetta, Legal Counsel said the OMC concluded this error was forgivable because a technician gave the wrong lens to the doctor. Ms. Cassetta said that in similar cases in the past the Board has issued disciplinary action because they have felt it is still the doctor's responsibility to ensure the proper item is used and the procedure is correct.

Lorraine Mackstaller, M.D. raised the question that if a technician hands the wrong lens to the physician, how would he determine it was incorrect since the lens is unlabeled? Dr. Nanney said the error occurred because the numbers for a different patient were entered into the chart for patient C.C.

Robert P. Goldfarb, M.D. said he felt this case was similar to a wrong site surgery and felt the Board should discuss this case with the physician in a Formal Interview to obtain more detail on this case. Dr. Goldfarb said that someone has to be responsible in cases such as these.

MOTION: Robert P. Goldfarb, M.D. moved to invite the physician for a Formal Interview.
SECONDED: Paul M. Petelin, M.D.

Douglas D. Lee, M.D. spoke against the motion because he said the doctor can not be responsible for the error because he is relying on the other professionals to do their job. Dr. Lee said it would be the same thing as if the nurse took a patient's blood pressure and wrote it on the wrong chart, and the doctor relied on that.

Paul M. Petelin, M.D. said the people who make the clerical errors are the doctor's employees and follow a system of checks and balances to prevent this type of error from happening. Dr. Petelin said the physician's system of checks and balances in this case failed.

VOTE: 6-yay, 5-nay, 0-abstain/recuse, 1-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
15.	MD-04-1274A	AMB	JEFFREY J. STEVENS, M.D.	11818	Advisory Letter for suboptimal pediatric anesthesia administration.
16.	MD-05-0826A	AHCCCS	ELIAS A. NALLI, M.D.	17326	Advisory Letter for an accidental incision site.

Elias A. Nalli, M.D. was present without counsel and spoke during the call to the public. Dr. Nalli, said he accidentally performed a superficial midline incision slightly higher than where he had planned to begin the incision. He said he informed the patient of his error and also documented the error in his operative report because he felt it was the right thing to do. The patient had no complications from the error.

Dona Pardo, R.N., Ph.D. pulled the case for discussion. Dr. Pardo noted that the reason for the physician's error in the incision site was because the drapes were inappropriately placed. Paul M. Petelin, M.D. noted that usually the surgeon drapes the patient, but the senior resident, scrub tech or the nurses can sometimes also drape the patient. Dr. Petelin noted that once a patient is draped you sometimes lose your reference points, and could see how this could happen. Dr. Petelin said this does not excuse the surgeon from making sure the

incision is in the right place. Douglas D. Lee, M.D. said he agreed it was the physician's responsibility to ensure the incision was in the correct location.

Dr. Petelin, said it was mitigating that the physician could have taken the upper the incision and continued downward midline to where he initially planned to begin surgery, because a midline incision allows surgery to be performed virtually anywhere in the abdomen and he believed the error was not a wrong side or wrong site incision. Dr. Petelin said it is commendable that the physician honestly acknowledged his error, as he could have avoided any action by the Board if he chose to cover the error up.

MOTION: Robert P. Goldfarb, M.D. moved to issue an Advisory Letter for an accidental incision site.
SECONDED: Patrick N. Connell, M.D.

Robert P. Goldfarb, M.D. said this is case is different than other cases of wrong side or site surgery because there are mitigating factors in this case and for that reason he does not find cause for disciplinary action.

Sharon B. Megdal, Ph.D. said she did not believe this was a wrong side surgery, but because of the error in making the superficial incision she supports the Advisory Letter.

VOTE: 10-yay, 0-nay, 1-abstain 0-recuse, 1-absent
Motion Passed.

MOTION: Lorraine Mackstaller, M.D. moved to issue Advisory Letters for items 2,3,5,8 and 15
SECONDED: Ram R. Krishna, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
Motion Passed.

APPEAL OF ED DISMISSALS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-04-0482A	N.P.	MICHAEL A. CHASIN, M.D.	8082	Uphold the Executive Director's Dismissal.

William Wolf, M.D., Medical Consultant presented the case. He said the Outside Medical Consultant supplemental report found Dr. Chasin did not deviate from standard of care. The case was dismissed by the Executive Director. N.P. submitted an appeal to the dismissal. After reviewing the appeal from the complainant, the Outside Medical Consultant found no evidence to change his conclusion of the case.

MOTION: Ram R. Krishna, M.D. moved to uphold the Executive Director's Dismissal.
SECONDED: Lorraine Mackstaller, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-05-0104A	A.M.	ROBERT J. SPIES, M.D.	12927	Uphold the Executive Director's Dismissal.

Complainant A.M. was present and spoke during call to public. A.M. said she saw Dr. Spies for an eyebrow lift and lower eyelid surgery. She said the first surgery failed and Dr. Spies attempted a correction rather than referring her to a specialist. She said she put her trust in Dr. Spies for the correction surgery because he told her it would be a simple procedure, although he said he had only done it once before. A.M. said she is now facing her 6th surgery and has pleating on one side of her eye and has had to wear tape constantly on the skin surrounding her other eye.

Dr. Nanney presented the case. The Outside Medical Consultant found no deviations from the standard of care and case was dismissed. The complainant provided a tape recording of a conversation with Dr. Spies. The Outside Medical Consultant reviewed the tape recording and found his decision in this case remained unchanged.

MOTION: Douglas D. Lee, M.D. moved to uphold the Executive Director's Dismissal.
SECONDED: Becky Jordan

Sharon B. Megdal, Ph.D. asked if the cause of the patient's problem is a rare but known complication of the procedure. Mark Nanney, M.D., Chief Medical Consultant responded it is a known complication of the procedure. He further explained the allegation, that the physician was not qualified to perform the correction procedure, was not sustained. He said it was acceptable that the physician had corrected only one procedure like this before, because it is a rare complication and most physicians would not have had many opportunities to correct this type of complication.

VOTE: 11-yay, 1-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

OTHER BUSINESS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-04-1094A	AMB	SCOTT R. WERNER, M.D.	17352	Accept Consent Agreement for Surrender of Active License.
2.	MD-05-0242A	AMB	JOHN W. HOWLEY, M.D.	22390	Offer Amended Consent Agreement for Letter of Reprimand for violating a Board Order and five year Probation for participation in MAP. The Amendment provides for revocation without a Formal Hearing in the event of relapse. If he does not accept the consent agreement, invite the physician for a formal interview.

This case was pulled for discussion.

Christine Cassetta, Legal Counsel said the physician has relapsed twice while licensed with the Board and suggested the Consent Agreement be amended to include language to be consistent with the Board's three-strike policy. If the physician agrees, he would waive formal hearing and, after the Board established a relapse, his license would be revoked. If he refused the amendment he would be invited to formal hearing and the Board could issue an Order with a term that refers the physician directly to Formal Hearing for revocation if a third relapse occurs.

MOTION: Patrick N. Connell, M.D. moved to offer the physician an amended Consent Agreement for Letter of Reprimand for violating a Board Order and five year Probation for participation in MAP. The Consent Agreement is amended to include revocation and waiver of Formal Hearing in the event of relapse. If he does not accept the consent agreement, invite the physician for a formal interview.
SECONDED: Ram R. Krishna, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-04-0903A	AMB	BETHANIE E. THORNGREN, M.D.	67913	Accept Consent Agreement for a Letter of Reprimand for self-prescribing.

Tim B. Hunter, M.D. recused himself from this case.

Patrick N. Connell, M.D. pulled the case for discussion. He summarized by saying this physician is a resident who had serious chemical dependency problems causing her to be dismissed from her residency. He noted the physician subsequently went to treatment.

Christine Cassetta, Legal Counsel advised the Board they could discipline the physician for behavior while in Arizona. However, the physician is no longer in Arizona and so Monitored Aftercare Program participation could not be imposed on the physician.

MOTION: Patrick N. Connell, M.D. moved to accept the Consent Agreement for Letter of Reprimand for self prescribing.
SECONDED: Ram R. Krishna, M.D.
VOTE: 11-yay, 0-nay, 0-abstain, 1-recuse, 0-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-05-0370A	AMB	MURALI D. TALLURI, M.D.	19237	Accept Consent Agreement for Letter of Reprimand for repeatedly failing to provide medical records to patients or other healthcare providers.
5.	MD-04-0893A	J.C.	ROBERT D. HUNN, M.D.	5215	Accept Consent Agreement for Letter of Reprimand for self-prescribing and prescribing to family members.
6.	MD-05-0163A	AMB	GARY L. LOWERY, M.D.	24907	Accept Consent Agreement for Surrender of Active License and immediate return of his license to the Board.
7.	MD-04-0639A	AMB	FRANKLIN H. BAROI, M.D.	22605	Accept Consent Agreement for a Decree of Censure for improper prescribing practices and inadequate record keeping. One Year Probation to obtain 20 hours CME in medical record keeping and 10 hours CME in prescribing controlled substances.

MOTION: Patrick N. Connell, M.D. moved to accept the Consent Agreements for items 1,4,5,6,7.
SECONDED: Ram R. Krishna, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
8.	MD-05-0620A	AMB	GEORGE E. STAVROS, M.D.	4409	Deny appeal of ED Referral to Formal Hearing.

Carol Peairs, M.D., Medical Consultant summarized the case for the Board. She said Dr. Stavros works at a clinic treating addicts and he is currently under a compliance program with the Board to monitor his documentation of patients. Dr. Peairs said the Outside Medical Consultant has reviewed multiple charts for this physician that all continued to demonstrate poor record keeping skills, despite the physician's attendance of 20 hours CME in record keeping, and despite the physician's prior Board history of a Probation and two Decree of Censures. SIRC found the physician is unrepentant and a third disciplinary action would not change his behavior.

MOTION: William R. Martin, III, M.D moved to deny the appeal of the Executive Director's Referral to Formal Hearing.
SECONDED: Patrick N. Connell, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
9.	MD-04-L300A	AMB	CHARLES M. BAZZELL, M.D.	N/A	Uphold Executive Director's Denial of License.

Charles M. Bazzell, M.D. was present and spoke during the call to the public. He said he obtained legal counsel before answering the questions on the Arizona Medical Board application and said he was advised to answer "no" to the questions relating to his professional conduct. He said that when he discovered the Board felt this to be a violation, he provided every document relating to the history in question and was fully cooperative with the Board's staff. He said he believes he would be an asset to the state of Arizona and has received several awards attesting to his outstanding abilities as a physician.

Marlene Young, Senior Medical investigator summarized the case. The Arizona Medical Board Staff initiated an investigation Dr. Bazzell after he failed to answer some questions correctly on his application, although he was aware of his history at the time he completed the application. She noted that SIRC recommended the physician's license be denied due to his dishonesty, as that would be consistent with what the Board has done in the past for similar cases.

Stephen Wolf, Assistant Attorney General said the questions in the application deal with facts of matters and not the legal conclusions. He said Dr. Bazzell was fully aware of the facts when completing the license application.

Sharon B. Megdal, Ph.D. noted that if the Board chose to deny the license, the physician could choose to reapply at any time.

MOTION: Sharon B. Megdal, Ph.D. moved to uphold the Executive Director's denial the license due to A.R.S. §32-1401 (27) (d) - Committing a felony, whether or not involving moral turpitude, or a misdemeanor involving moral turpitude. In either case, conviction by any court of competent jurisdiction or a plea of no contest is conclusive evidence of the commission and A.R.S. §32-1401 (27) (jj) - Knowingly making a false or misleading statement to the board or on a form required by the board or in a written correspondence, including attachments, with the board.

Dr. Megdal said she did not feel it was relevant to include the statute pertaining to fraud in the motion.

Douglas D. Lee, M.D. asked if the physician unintentionally answered the questions incorrectly due to bad legal advice should he still be punished. Mr. Wolf said that even if the questions were answered incorrectly in good faith in advice obtained, the physician was still responsible for the answers because it was his signature that was ultimately on the application. Tim B. Hunter, M.D. commented that it may be somewhat mitigating that the physician sought legal advice. Lorraine Mackstaller, M.D. said the application questions are straight forward and legal advice is not needed to answer them.

Christine Cassetta, Legal Counsel advised the Board that the physician is ultimately responsible for the answers on the application, even if wrong legal advice is given.

SECONDED: William R. Martin, III, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D., Paul M. Petelin, Sr., M.D. The following Board Member abstained: Ronnie R. Cox, Ph.D. The following Board Member was absent: Robert P. Goldfarb, M.D.
VOTE: 10-yay, 0-nay, 1-abstain, 0-recuse, 1-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
10.	MD-05-L141A	AMB	MICHAEL M. BERMUDEZ, M.D.	N/A	Uphold Executive Director's Denial of License.

Marlene Young, Senior Medical Investigator summarized the case. She said that Dr. Bermudez failed to disclose peer review on his application or any disciplinary actions although he had been under peer review in the state of Kansas and had received termination of employment in the state of Kansas.

Tim B. Hunter, M.D. Hunter said, that the doctor claims that at the time he completed the application he was not under investigation. Ms. Young said he under investigation and was aware of the investigation and peer review. Ms. Young referred to dated documents to verify his knowledge of the events.

MOTION: Ram R. Krishna, M.D. moved to deny the license based on violation of A.R.S. §32-1401 (27) (jj) - Knowingly making a false or misleading statement to the board or on a form required by the board or in a written correspondence, including attachments, with the board and A.R.S. §32-1427 (B)(1)- All of the information contained in the application and accompanying evidence or other credentials are true.
SECONDED: Paul M. Petelin, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
11.	MD-04-0186A MD-04-0925A	PSYCH BOARD W.F.	HOWARD L. MITCHELL III, M.D.	30004	Accept Findings of Fact, Conclusions of Law and Order for Decree of Censure for inappropriate prescribing and monitoring of medications, specifically amphetamines, ignoring data when evaluating a patient; making a custody recommendation without an appropriate evaluation; and making false statements in a patient evaluation and a one year Probation with 20 hours CME in pharmacology.
12.	MD-03-0239A	STATE COMP. FUND	WILLIAM E. MORA, M.D.	13088	Accept Findings of Fact, Conclusions of Law and Order for Letter of Reprimand for performing unnecessary tests, billing irregularities and unbundling codes and one year Probation with 10 hours CME in ethics and 10 hours CME in coding and billing.
13.	MD-05-0171A	J.S.	CHARLES A. CALKINS, M.D.	9848	Accept Findings of Fact, Conclusions of Law and Order for Letter of Reprimand for performing an unscheduled carpal tunnel on a patient prior to performing the correct procedure.
14.	MD-03-0246A	AMB	D. PAUL KNAPP, M.D.	22830	Accept Findings of Fact, Conclusions of Law and Order for Decree of Censure for action taken against him by other licensing and regulatory Board for acts of unprofessional conduct as prescribed by Arizona law and five year Probation to not supervise physician assistants and shall provide the Board a plan of practice for monitoring of the physician's license by another physician.
15.	MD-04-0894A	AMB	CHARLES A. BOLLMANN, M.D.	6020	Accept Findings of Fact, Conclusions of Law and Order for Letter of Reprimand for using Xanax without a prescription written by another physician and for engaging in sexual conduct with patients and a 2 year Probation with 10 hours CME in Ethics and 10 hours CME in boundary violations.
16.	MD-04-1108A	AMB	TERRY R. MAXON, M.D.	4717	Accept Findings of Fact, Conclusions of Law and Order for Letter of Reprimand for failure to properly monitor and treat a patient with gastrointestinal bleeding, eventually resulting in the death of the patient.
17.	MD-05-0949A	AMB	JAMES D. GADD, M.D.	8696	Accept Findings of Fact, Conclusions of Law and Order for for three year Probation with inpatient treatment and practice restriction from practicing any clinical medicine or any medicine involving direct patient care. Is prohibited from prescribing any form of treatment including prescription medications until completing inpatient treatment and receiving permission from the Board to practice.

William R. Martin, III, M.D. recused himself from this case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
18.	MD-04-1477A	R.S.	ANTHEA DIXON, M.D.	11202	Accept Findings of Fact, Conclusions of Law and Order for Letter of Reprimand for failure to identify a large mass and a large amount of fluid in the abdomen.

Robert P. Goldfarb, M.D. and Lorraine Mackstaller, M.D. recused themselves from this case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
19.	MD-04-1116A	AMB	JOSE PADILLA, M.D.	25251	Accept Findings of Fact, Conclusions of Law and Order for Letter of Reprimand for failure to timely diagnose a transsection of the popliteal artery resulting in the amputation of a patient's limb.

MOTION: Patrick N. Connell, M.D. moved to accept the Findings of Fact, Conclusions of Law and Order for items, 11,12,13,14,15,16,17,18,19.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion:
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
20.	MD-01-0861	AMB	MARVIN L. GIBBS, M.D.	13736	Modify Board Order of Probation to grant an extension until September 1, 2006 to pay the fine.

Sue Dana, Compliance Officer summarized the case for the Board. She said Dr. Gibbs requested an extension to comply with a term of his Probation Order requiring him to pay a fine. She said he requested the extension before his deadline expired, however, Board Staff had not completed processing his request when the deadline expired, thus making him in violation of his Board order. Dr. Gibbs said he could not pay the fine initially because the disciplinary action he received made it difficult for him to obtain employment. She said he is now employed and able to complete this term of his Probation Order.

MOTION: Douglas D. Lee, M.D. moved to modify the Board Order of Probation to grant an extension until September 1, 2006 to pay the fine.
SECONDED: Paul M. Petelin, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
21.	MD-04-0057A	AMB	LAWRENCE E. PRITCHARD, M.D.	19260	Lift the Stayed Revocation and Revoke the license.

Kathleen Muller, Physician Health Program Manager summarized the case for the Board stating the physician has violated the terms of his Board order in that he has not entered into an inpatient treatment program for chemical dependency or paid the Administrative Hearing costs.

MOTION: Patrick N. Connell, M.D. moved to find the physician in violation of the Findings of Fact, Conclusions of Law and Order for Stayed License Revocation and Suspension, to lift the stay and revoke the license.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D., Paul M. Petelin, Sr., M.D.

WEDNESDAY, FEBRUARY 8, 2006

CALL TO ORDER

Tim B. Hunter, M.D. called the meeting to Order at 9:30 a.m.

ROLL CALL

The following Board Members were present: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D, Paul M. Petelin, M.D. The following Board Member was absent: Robert P. Goldfarb, M.D.

CALL TO THE PUBLIC

Statements issued during the Call to the Public appear beneath the case referenced.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-04-0608A	AMB	JOEL G. COHEN, M.D.	8027	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for placing the incorrect graft during septoplasty and for inadequate medical records.

Douglas D. Lee, M.D. said he knows Dr. Nate Tritle, the Outside Medical Consultant in this case, but it will not affect his ability to adjudicate the case.

Joel G. Cohen, M.D. was present with counsel, Mr. David Cohen.

Gerald Moczynski, M.D., Medical Consultant summarized the case. The case was brought to the attention of the Arizona Medical Board after a malpractice settlement was made on behalf of Dr. Cohen. Dr. Cohen initially evaluated the patient for chronic sinusitis and operated on her nose. Post surgery the patient complained of a bump on bridge of nose. He advised the patient he placed a dorsal strut and recommended observation and follow up in seven days. In a subsequent letter to the patient's primary care physician he said he placed a cartilage graft that may need to be moved. The patient followed up with another physician who removed the graft and placed it in a more typical location in the collumella. The Outside Medical Consultant felt Dr. Cohen deviated from the standard of care in placing a dorsal cartilage graft and not a strut graft and not dictating that part of the procedure in his operative note.

Dr. Cohen said he has been practicing in Arizona for 32 years, and has received six Advisory Letter letters total over those years. He said he feels he has a pattern that supports his good medicine. Dr. Cohen said that although his procedure for the patient was intended to be only a septoplasty for a deviated septum. However, at the end of the operation he noticed the patient had a saddle nose defect and felt he could save the patient a second operation by correcting the defect at that time. Dr. Cohen said he believes he placed the graft in the right position. He said the day after the surgery he saw the patient and she looked fine and had no complaints. Dr. Cohen said he believes something happened post-operatively to make the graft prominent, such as the patient manipulating her nose by possibly repeatedly touching the area.

Paul M. Petelin Sr., M.D. led questioning and asked about the location where the graft was placed. Dr. Cohen said the Outside Medical Consultant agreed with him that the standard of care is that it is up to the discretion of the physician on how to place the graft. Dr. Petelin clarified by stating the Outside Medical Consultant further commented that Dr. Cohen deviated from the standard of care in the way he placed the graft and by his suggestion to remove the graft in an office setting rather than a hospital setting. Dr. Petelin also noted it was not documented in the medical record prior to surgery that he would be correcting a saddle nose deformity. Dr. Cohen said that his informed consent covers the basis for procedures he cannot foresee. Dr. Petelin asked if he would place a strut graft in the future for a similar case. Dr. Cohen said the only thing he would change if this type of case occurred again, would be to improve his documentation in the medical record, but he would still place the graft wherever he believed was necessary in order to correct a saddle nose and that he firmly believed this patient needed a dorsal graft.

Dr. Petelin noted that in the patient's follow up office visit Dr. Cohen did realize there was a problem and offered to remove the graft in his office under local anesthesia. Dr. Petelin said that other experts in this case have said this procedure should not be done in an office setting under local anesthesia. Dr. Petelin also noted it was Dr. Cohen's testimony that the graft was 2-3 cm, but that the medical record did not support this in that it did not document that a graft was even performed. Dr. Cohen said he has no explanation or excuse for not documenting the placement of the graft and did not have any reason to hide it.

Dr. Petelin referred to the computed tomography (CT) scan ordered by Dr. Locnikar approximately five weeks post-operative and compared it to the pre-operative CT scan. Dr. Petelin said the post-operative CT scan showed that the patient's nose had become worse rather than better. Dr. Cohen agreed things appeared worse and said that post-op changes in x-rays are very common. He said he believed that because the patient did not come back for post-op care, to allow him to clean or suction the nose, he feels it affected the patient's recovery.

Dr. Petelin noted the patient followed up with two other surgeons following the surgery he performed and had two other surgeries. He said that one of the surgeons described the graft Dr. Cohen placed as being asymmetrical and he then replaced the graft.

The Board went into Executive Session at 10:03 a.m.
The Board returned to Open Session at 10:07 a.m.

Christine Cassetta, Legal Counsel notified the Board that one of physicians who treated the patient in this case after Respondent, Steven Locnikar, D.O., had his license Revoked in January 2006 for substance abuse. She said it is not known if substance abuse was a problem for the physician at the time he treated the patient and wrote his chart and the Board may still use as reference any tests or laboratory results he ordered. The Board chose not to comment further on Dr. Locnikar's follow up of the patient.

Dr. Petelin referred to Dr. Leighton's report almost five months post-surgery that noted a floating piece of cartilage over the nose. Dr. Cohen said that usually if the graft was left alone and not manipulated on a regular basis, the graft would have taken root. He felt the patient may have constantly touched it and caused it to shift, not allowing it to heal.

Mr. David Cohen summarized his client's response by stating Dr. Cohen's placement of the graft was necessary to prevent a rhinoplasty. He said the patient's post operative problems were due to either the pre-existing conditions and/or the patient's lack of follow up. He said it is their position that the graft was not allowed to heal and that Dr. Cohen does not excuse his mistake of not documenting the graft in his notes.

Dr. Petelin said in light of the evidence and the physician's testimony in this case, he finds there has been unprofessional conduct in that the standard of care was to place a dorsal graft and not a strut graft in the patient. He said he also found actual harm in that the patient underwent additional surgeries.

MOTION: Paul M. Petelin, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401(27)(ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient and A.R.S. §32-1401 (27)(e)- Failing or refusing to maintain adequate records on a patient.

SECONDED: Ram R. Krishna, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
Motion Passed.

Dr. Petelin said he's taken into account the number of years Dr. Cohen has been in practice, and the six Advisory Letters he has accumulated over the six years. He said that although the previous Advisory Letters do not reflect similar activity, it does reflect a pattern of the physician coming before the Board.

MOTION: Paul M. Petelin, M.D. Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for placing the incorrect graft during septoplasty and for inadequate medical records.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D, Paul M. Petelin, M.D.
The following Board Member was absent: Robert P. Goldfarb, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-04-1428B	B.R.	WILLIAM BOHNERT, M.D.	5456	Dismissed.

Paul M. Petelin, M.D. recused himself from this case.

B.R. was present and spoke during the call to the public regarding her father's death under the treatment of Dr. Bohnert. She said her own care for treatment of cancer with another physician was at a much higher standard than the care her father received even though his condition was worse than hers. She said Dr. Bohnert was not forthcoming with her father's pathology report, never disclosed the existence of cancer or referred him to see another specialist. She said Dr. Bohnert told her family that her father was cancer free although he told the patient's primary care physician that there was cancer in the patient. She alleged Dr. Bohnert did not act on the pathologist's warning. She said that her father was allowed to go one year without treatment before he was told he had cancer. She said her father deserved a choice of cancer treatment.

William Bohnert was present with counsel, Mr. Barry A. MacBan.

Kelly Sems, M.D., Medical Consultant presented the case to the Board. She said the complaint alleges Dr. Bohnert failed to inform patient T.R. and the family of that T.R. had cancer. It was also alleged Dr. Bohnert failed to refer the patient to specialists after surgery, allegedly failing to give him the chance at prolonged life. It is also alleged that when T.R. complained of back pain, Dr. Bohnert did not do an adequate workup to for the pain, which may have led to discovery of cancer. The Outside Medical Consultant found that if Dr. Bohnert disagreed with a radiologist's reading on the patient should have contacted the radiologist in order to read the report together and discuss the differing opinions.

Dr. Bohnert summarized his patient care in this case. Dr. Bohnert said he had a good physician/patient relationship with T.R. and saw the patient initially in 1993. He said he initially diagnosed bladder tumor and cancer in the patient and successfully led him through management of those diseases. He said T.R. did not have a recurrent lesion for 7 years. Dr. Bohnert said that in the year 2000, the patient developed a recurrent tumor and he discussed options with both T.R. and T.R.'s wife. Both T.R. and his spouse were strongly opposed to a cystectomy. He said he did not perform a cystectomy and the patient was again disease-free for a couple of years. Dr. Bohnert said the patient later had a recurrence of a bladder tumor in addition to carcinoma in situ. He said the patient was still opposed to a cystectomy, but about a year later the patient then had another recurrence. He said, at that point, he told the patient there was a possibility that he could have pelvic lymph node metastasis and, if so, the patient would have the option of chemotherapy or cystectomy. Dr. Bohnert said it is his belief that if he the patient would have had a cystectomy in 2001 he would not have passed away. Dr. Bohnert said that the patient eventually went through with a cystectomy. Dr. Bohnert said that post-surgery he told the patient and his family there was a small lymph node in the fatty tissue behind the bladder, but that it was well contained. He said it was the standard of care at that point to watch the lymph node rather than to administer chemotherapy. Dr. Bohnert said he did evaluate the patient when he complained of back pain, but the bone scan was negative for metastatic disease.

Ram R. Krishna, M.D. led the questioning. Dr. Bohnert said it is normal practice to do a follow up cystectomy every six months and although he did follow up regularly he did not notice a reoccurrence. Dr. Krishna noted the radiologist was confident the patient had developed cysts. Dr. Bohnert said he did not see any clinical indications that the patient was failing and so he was surprised at the radiologist's findings. He said he had his partner look at the radiology report twice and his partner also did not see a finding of cysts. Dr. Bohnert says he agrees he should have taken the films to the radiologist to review them with him. Dr. Bohnert said he was monitoring the patient at that point by watching for clinical signs to see if the patient was failing. Dr. Bohnert said he believes chemotherapy would have

been more harmful to the patient and it would not have been the standard of care to treat the patient with chemotherapy following the cystectomy.

William R. Martin, III, M.D. commented on the allegation that Dr. Bohnert did not appropriately address the patient's back pain. He said that a rare cancer may not be positive on a bone scan and that he felt that other advanced testing should have been ordered.

Douglas D. Lee, M.D. asked Dr. Bohnert what he would do differently if a similar case occurred in the future. Dr. Bohnert said he would have better documented the extensive efforts he made to be honest with the patient and tell him everything about the disease. He said he also usually gives the patient their pathology report and goes over it with them line by line and is sure he did that in this case. However, Dr. Bohnert said he wished he would have documented these things better.

Dr. Bohnert's Counsel, Mr. MacBan summarized their response by saying a Mayo clinic physician reviewed the films in this case and found Dr. Bohnert's care to be exemplary. Mr. MacBan felt this complaint was the result of a misunderstanding by a family member. He said there are no quality of care issues to sustain in this case and that Dr. Bohnert is a compassionate and caring doctor.

Dr. Krishna said that he found after the interview with doctor, there is no question the physician is competent. Dr. Krishna said he agrees with Bohnert that chemotherapy would have worsened the quality of life for the patient during anytime his life may have been lengthened.

MOTION: Ram R. Krishna, M.D. moved to Dismiss the case.
SECONDED: William R. Martin, III, M.D.

Dr. Martin said he believed Dr. Bohnert presented himself to the Board in a knowledgeable manner. He said his only concern was that Dr. Bohnert did not document the second opinion he received on the radiology film. Dr. Martin said that apart from that it did not appear the patient's outcome would have been different had another course been taken. Dr. Martin spoke in favor of the motion.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D. The following Board Member was recused: Paul M. Petelin, M.D. The following Board Member was absent: Robert P. Goldfarb, M.D.
VOTE: 10-yay, 0-nay, 0-abstain 1-recuse, 1-absent.
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-05-0184A	AMB	RONALD S. SHERER, M.D.	19367	Draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure for gross negligence in the management of a known diabetic patient who was pregnant and had a very high probability that mismanagement could lead to fetal demise. Fifteen (15) year Probation with practice restriction to not practice obstetrics.

Ronald S. Sherer, M.D. was present with counsel, Mr. Kent Turley.

Ingrid Haas, M.D., Medical Consultant summarized the case. She said the patient presented in first trimester with past history of hypertension and diabetes. The patient was seen on a regular basis by Dr. Sherer and Accu-Cheks were the only evaluations of blood sugar done in the office. The patient was not changed to insulin until her last trimester, and fetal monitoring was not instituted until 34 weeks. The infant died prior to delivery.

Dr. Sherer said the patient was initially referred to him by a physician who said the patient should see a perinatologist, but since the patient could not afford that, he thought the patient would be a good candidate for Accu-Chek at home. However, the patient did not consistently and thoroughly monitor her blood sugar at home, and failed to provide complete reports of her levels to Dr. Sherer. Dr. Sherer said that when he realized the patient was not appropriately monitoring her blood sugar at home, by failing to providing him thorough reports, he did a blood sugar test for the patient and realized her blood sugar level was dangerously high. At that point he referred the patient to a perinatologist for fetal monitoring and told the patient he was no longer able to see her. Dr. Sherer said two weeks later the patient again returned to him stating she had not seen a perinatologist for fetal monitoring because she could not afford it.

Douglas D. Lee, M.D led the questioning. Dr. Sherer said covers obstetric patients for another physician part of the time and the other physician did see the patient on a couple of occasions. He said, however, this patient was not co-managed. Dr. Sherer said 4-5% of his patients are high risk, but that he would classify this patient as a higher risk than most of his patients. Dr. Sherer said he admits this patient should have been sent to a perinatologist from the beginning and her initial visit with him should have included a test to determine where her blood sugar levels where for the previous 4-8 weeks.

Dr. Lee asked Dr. Haas her opinion on what the cause of the infant's death was. Dr. Haas said she believed this case was more than a diabetic issue. Dr. Haas said the patient had hypertension prior to pregnancy, and believes that contributed first to the demise of the fetus, and the patient's diabetes contributed secondly.

Paul M. Petelin, Sr., M.D. noted the first time Dr. Sherer referred the patient to a perinatologist was at 31 weeks into the pregnancy.

Both Dr. Petelin and Patrick N. Connell, M.D. found it concerning that Dr. Sherer did not have his staff assist the patient in obtaining financial medical aid through any federal services so that she would be able to see a perinatologist.

William R. Martin, III, M.D. asked Dr. Sherer what he would do differently now if presented with the same situation again. Dr. Sherer said he would not have taken the patient or would have or would have monitored the patient appropriately if he did assume care.

MOTION: Douglas D. Lee, M.D. moved for a finding of unprofessional conduct in violation of A.R.S. § 32-1401(27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public and A.R.S. §32-1401 (27) (ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Lorraine Mackstaller, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
Motion Passed.

Dr. Lee said he believes disciplinary action is necessary because true patient harm was done to the fetus and potential harm was done to the mother. He said this case should also be viewed in light of prior disciplinary actions with the board.

The Board went into Executive Session at 12:35 a.m.
The Board returned to Open Session at 12:42 a.m.

MOTION: Douglas D. Lee, M.D. moved to Draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure for gross negligence in the management of a known diabetic patient who was pregnant and had a very high probability that mismanagement could lead to fetal demise. Fifteen (15) year Probation with practice restriction to not practice obstetrics.
SECONDED: Paul M. Petelin, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Tim B. Hunter, M.D., Becky Jordan, Douglas D. Lee, M.D., Dona Pardo, R.N., Ph.D., Paul M. Petelin, Sr., M.D. The following Board Members voted against the motion: Ronnie R. Cox, Ph.D., Ram R. Krishna, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., The following Board member was absent: Robert P. Goldfarb, M.D.
VOTE: 6-yay, 5-nay, 0-abstain/recuse, 1-absent
Motion Passed.

CALL TO THE PUBLIC – 1:15 p.m.

Statements issued during the Call to the Public appear beneath the case referenced.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-05-0481A	M.B.	STANLEY ZIMMERMAN, M.D.	9666	Advisory Letter for missing a lab result. This is a technical error.

Stanley Zimmerman was present with Counsel Robert Milligan.

Patrick N. Connell, M.D. and William R. Martin, III, M.D. said they know Mr. Milligan on a professional basis, but it will not affect their ability to adjudicate the case.

Roderic Huber, M.D., Medical Consultant summarized the case to the Board. Dr. Huber said the allegation was that Dr. Zimmerman did not notice a side reaction to the statin medications he had prescribed for a patient. Dr. Huber noted that although Dr. Zimmerman did not notice the patient's side reaction, another physician saw the patient, realized there may be a problem and discontinued the Lipitor. The patient was eventually diagnosed with polymyositis, was in treatment for many months and is still somewhat unstable.

Dr. Zimmerman said he failed to notice an abnormal liver function tests for the patient due to a technical error. He said he believes he did not scroll down far enough on the computer screen to make sure all the lab work had been read. Dr. Zimmerman said he has made changes since this incident on how lab work and x-rays are reviewed so that a similar error can be prevented in the future. Dr. Zimmerman said the test he performed on the patient was not prompted by complaints or abnormalities by the patient, but was simply requested by Dr. Zimmerman to monitor lipid and liver function. Dr. Zimmerman said that three weeks after the test was missed, the patient complained of muscle weakness and at that point he recognized the problem was the Lipitor and he told the patient's new physician the patient needed to be hospitalized immediately.

Douglas D. Lee, M.D. led the questioning and had Dr. Zimmerman elaborate on what type of evaluations he usually does for patients to whom he prescribes statins. Paul M. Petelin, Sr., M.D. asked Dr. Zimmerman if he would have recognized the abnormal labs how that would have changed his treatment. Dr. Zimmerman said his treatment would have begun sooner for the patient, but he would have taken the same course of treatment.

Mr. Milligan said Dr. Zimmerman understands the significance of his error in this case and believes this was a one-time system error.

MOTION: Douglas D. Lee, M.D. moved to issue an Advisory Letter for a technical error for missing a lab result. This is a technical error.
SECONDED: Lorraine Mackstaller, M.D.

Douglas D. Lee, M.D. said it is good that the physician's chart is incredibly easy to follow, and that the lab result was in the chart. However, Dr. Lee said action must be taken by the Board because it is the physician's testimony that he overlooked the lab work.

Ram R. Krishna, M.D. said he disagrees with the motion because he said the physician's testimony before the board proved his competency in this matter.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Ronnie R. Cox, Ph.D., Tim B. Hunter, M.D., Becky Jordan, Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D, Paul M. Petelin, Sr., M.D. The following Board members voted against the motion: Patrick N. Connell, M.D., Ram R. Krishna, M.D. The following Board Member was not present: Robert P. Goldfarb, M.D.
VOTE: 9-yay, 2-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
6.	MD-04-1340A	AMB	THOMAS W. GLODEK, M.D.	27919	Dismissed.

William R. Martin, III, M.D. recused himself from the case.

Thomas Glodek, M.D. was present with counsel, Ms. Mandi Karvis.

Ingrid Haas, M.D., Medical Consultant summarized the case to the Board. The case came to Arizona Medical Board as the result of a malpractice settlement on behalf of Dr. Glodek. Dr. Glodek delivered a still born infant and the allegation is that he failed to perform a C-section in a timely manner.

Patrick N. Connell, M.D. led the questioning. Dr. Connell noted this patient was a higher risk because of her age and non-stress test would have been good because the fetus would have been mature enough to respond. Dr. Connell said the autopsy report said the infant suffered injury days or weeks before delivery. Dr. Glodek said he disagreed with the autopsy report and found it hard to determine when the injury occurred because the patient, all along, had reported fetal movement.

Dr. Glodek said when the patient was admitted to the hospital on the final day of this case, he viewed a strip for the patient that was non-reactive strip, no accelerations were noted, but there were decelerations. Dr. Connell said subtle decelerations would note the infant was in trouble and the ACOG guidelines indicate the need for a 30 minute C-section at that point. Dr. Connell said it appeared to him Dr. Glodek performed an urgent C-section rather than an emergent C-section. Dr. Glodek said he meant for the C-section to be emergent, but there was a system error with the hospital in that there was not scheduled anesthesiologist for the labor and delivery area at that time. He said there was a delay with the Staff in notifying the anesthesiologist, and a delay in the time it took the anesthesiologist to arrive. Dr. Glodek said he knew the patient well, paid close attention to pre-natal care, offered comprehensive medical care and appropriate testing, and used his best clinical judgment in this case. He said the delay in the anesthesiologist's arrival was not the medical care he chose to involve himself in and he subsequently left the hospital as a result. He said this has been a heart-breaking case for him and he has since changed his practice to be even more proactive than before.

Ms. Karvis, counsel for Dr. Glodek, said Dr. Glodek saw the patient, did an ultrasound, saw fetal movement and amniotic fluid. She said that Dr. Glodek was proactive in that when he saw an abnormal strip he immediately recommended C-section. Ms. Karvis noted Dr. Glodek has not had any similar incidents before this one or since this time.

Dr. Connell said had reviewed this case in detail. He said this case resulted in a tragic outcome, but thinks Dr. Glodek answered the Board's questions to his satisfaction. Dr. Connell said he found several mitigating factors in this case on behalf of Dr. Glodek and did find the patient was closely followed. Dr. Connell said he found the physician exercised reasonable judgment in this case.

MOTION: Patrick N. Connell, M.D. moved to dismiss the case.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D, Paul M. Petelin, Sr., M.D. The following Board Member recused from the case: William R. Martin, III, M.D. The following Board member was absent: Robert P. Goldfarb, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 1-recuse, 1-absent
MOTION PASSED.

FORMAL HEARING MATTERS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-05-0868A	AMB	JOHN C. WOODS, M.D.	19005	License Revoked.

Stephen Wolf, Assistant Attorney General presented the case to the board. He said a Formal Hearing was conducted on November 23, 2005 and the Administrative Law Judge recommended Revocation due for aggravated assault and kidnapping in violation of A.R.S. §32-1401(27)(d) - Committing a felony, whether or not involving moral turpitude, or a misdemeanor involving moral turpitude. In either case, conviction by any court of competent jurisdiction or a plea of no contest is conclusive evidence of the commission.

MOTION: Ram R. Krishna, M.D. moved to accept the Findings of Fact and Conclusions of Law as presented by the Administrative Law Judge.
SECONDED: Patrick N. Connell, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

MOTION: Douglas D. Lee, M.D. moved to accept the Order of Revocation.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-05-0885A	AMB	TAMMY L. TADOM, M.D.	31547	License Revoked.

Stephen Wolf, Assistant Attorney General presented the case to the Board. He said a Formal Hearing was conducted and the Administrative Law Judge (ALJ) found unprofessional conduct for A.R.S. §32-1401 (27)(g) - Using controlled substances except if prescribed by another physician for use during a prescribed course of treatment. And A.R.S. §32-1401 (27)(dd)- Failing to furnish information in a timely manner to the board or the board's investigators or representatives if legally requested by the board.

Mr. Wolf said the ALJ recommended revocation. However, following the hearing Dr. Tadom's attorney notified Mr. Dean Brekke, Assistant Attorney General that Dr. Tadom had been attending long-term substance abuse treatment. It was Mr. Brekke's recommendation to the Board to issue an indefinite Suspension until treatment was complete.

MOTION: Ram R. Krishna, M.D. moved to accept the Findings of Fact and Conclusions of Law as presented by the Assistant Attorney General.
SECONDED: Douglas D. Lee, M.D.

Dr. Hunter said he feels the recommendation for Revocation of license should stand because the physician has not made an effort to work with Board during the length of this case.

MOTION: Sharon B. Megdal, Ph.D. moved to accept the Order for Revocation as recommended by the Administrative Law Judge.
SECONDED: Douglas D. Lee, M.D.

William R. Martin, III, M.D. said the physician's illness may have prohibited her cooperation with the Board and Revocation may close the door for rehabilitation. Sharon B. Megdal, Ph.D. said the Board should not have to chase a physician for rehabilitation and feel the Board has gone above their duty to the physician in this case.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D, Paul M. Petelin, Sr., M.D. The following Board Member was not present: Robert P. Goldfarb, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

OTHER BUSINESS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-03-1280A	T.H.	MARVIN L. GIBBS, M.D.	13736	Deny the motion for rehearing.

William R. Martin, III, M.D. pulled this case for discussion. Stephen Wolf, Assistant Attorney General summarized the case for the Board. Marvin L. Gibbs, M.D. requested a rehearing of his case because he claimed the Board did not have an opportunity to review his supplemental response and he did not have a chance to defend himself adequately. Mr. Wolf advised the Board that these allegations had no merit. Mr. Wolf did say, however, that the hospital peer review the Board considered in this case was not completely sufficient. He said the hospital had erroneously believed Dr. Gibbs had prior action taken by the Arizona Medical Board and relied on that assumption when judging the matter before them. Mr. Wolf recommended the case be rescinded and returned for further investigation based on this finding.

Sharon B. Megdal, Ph.D. said the Board reviews cases independently, examines the facts themselves and does not rely upon another's investigation such as a peer review body to make their decisions. Dr. Megdal said she did not believe this case should be reconsidered.

Ram R. Krishna, M.D. said the physician admitted to not signing medical records. Lack of signature on the record constitutes incomplete medical records. Dr. Krishna said Dr. Gibbs is in violation for incomplete medical records by his own admission.

MOTION: Ram R. Krishna, M.D. moved to deny the motion for rehearing.
SECONDED: Sharon B. Megdal, Ph.D.
VOTE: 10-yay, 1-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-04-0769A	N.D.	STUART Z. LANSON, M.D.	7318	Deny the motion for rehearing.

Paul J. Ginacola, legal counsel, was present on behalf Stuart Z. Lanson, M.D. Mr. Giancola requested rehearing regarding a Letter of Reprimand issued on Dr. Lanson's license based on: new information provided to the Board, questionable qualification of the Medical Consultant who reviewed the case, and disciplinary action taken by the Board in this case was felt to be too excessive. Mr. Giancola said

the Medical Consultant admitted he was not qualified to review the case and yet the Board used his opinion anyway. Mr. Lanson said the peer review committee of environmental physicians reviewed the case and found Dr. Lanson had met the standard of care. He concluded by saying there was no documented harm done to the patient.

Mr. Timothy Miller, J.D., Executive Director addressed the allegation against the Medical Consultant the Arizona Medical Board staff chose to review the case. He said the AMB staff does not have to choose a Medical Consultant with the exact specialty of the case they are reviewing. He also said that the medical specialty of environmental physicians is a rare specialty, with few specialists to choose from and the specialty is not recognized by the American Board of Medical Specialties or the Arizona Medical Board. Mr. Miller said AMB Staff appropriately chose a well qualified physician with a similar specialty and with a specialty that was recognized by the Board.

The Board went into Executive Session at 4:07 p.m.
The Board returned to Open Session at 4:18 p.m.

Tim B. Hunter, M.D. said the Medical Consultant in this case is a well recognized physician with ample qualification to review the case in that he specialized in Internal Medicine. Dr. Hunter said the particular Medical Consultant used was familiar with the standard of care in the community and was well qualified to review the evidence in the case against Dr. Lanson. Dr. Hunter said that he also found that the additional information provided to the Board was actually included in the Board's initial review of the case and he did not consider it to be relevant. Dr. Hunter said the information that was claimed to be new was actually a report of the unrecognized specialty in reaction to the Board's order. Dr. Hunter said he may be willing to agree that the penalty in this case may be excessive.

Patrick N. Connell, M.D. said it is not necessary to always find a consultant whose specialty is perfectly matched and he believes that an appropriate expert testified in this case. Dr. Connell also felt that the new evidence presented was not new. Dr. Connell said the Board conducted an extensive interview and found Dr. Lanson did not meet standard of care and the Letter of Reprimand was appropriate.

MOTION: Sharon B. Megdal, Ph.D. moved to deny the motion for rehearing.
SECONDED: Patrick N. Connell, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-04-0236A	C.R.	KENNETH M. FISHER, M.D.	12762	Deny the motion for rehearing.

Mr. Michael Golder, legal counsel for Kenneth M. Fisher, M.D. was present on behalf of Dr. Fisher and spoke during the call to the public. Mr. Golder said he was concerned Dr. Fisher did not receive due process during his Formal Interview and also believes the Board should have heard the case from the standpoint of a family care physician. Finally, he said he was not allowed to cross examine the Medical Consultant in this case. Based on these points Mr. Golder requested the entire matter be reheard.

Stephen Wolf, Assistant Attorney General summarized the case for the Board. He said the physician did receive due process, and there was no right to cross examine the medical consultant. Mr. Wolf said he supported a limited rehearing that would not review the entire case again, but only reconsider the findings of fact in the case. Christine Cassetta, Legal Counsel for the Board said she did not agree that the findings of fact needed to be amended in the physician's Order and noted the findings as proposed did not meet the requirements of the *Webb* case. Patrick N. Connell, M.D. said the doctor did testify to the things written in the finding of fact and so there was sufficient evidence to support the Order. Dr. Connell said he approved of the method in which the Board's Orders are currently drafted and did not feel the findings of fact needed to be amended for the physician's Order.

MOTION: Patrick N. Connell, M.D. moved to deny the motion for rehearing.
SECONDED: Paul M. Petelin, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-04-0296A	MARY-VALE HOSP.	BERND JACOB, M.D.	10119	Accept the Consent Agreement for Letter of Reprimand for failing to appropriately monitor labor and delay in delivery.

Mr. Michael Ross, legal counsel, was present on behalf of Bernd Jacob, M.D. for case MD-04-0296 only. He said Dr. Jacob is retired from medicine and was in the hospital, terminally ill. He requested the Board accept the signed Consent Agreement for Letter of Reprimand for failing to appropriately monitor labor and delay in delivery.

MOTION: Ram R. Krishna, M.D. moved to accept the Consent Agreement for Letter of Reprimand for failing to appropriately monitor labor and delay in delivery for case MD-04-0296A. Additionally, to accept the Consent Agreement for Letter of Reprimand for failing to appropriately manage a high risk pregnancy by failing to hospitalize the patient for a perinatologist consultation upon obtaining conflicting test results that may have indicated intrauterine growth restriction more than two weeks prior to delivery for cases MD-01-0052, MD-02-0083A.
SECONDED: Ronnie R. Cox, Ph.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-01-0052 MD-02-0083A	AMB AMB	BERND JACOB, M.D.	10119	Accept the Consent Agreement for Letter of Reprimand for failing to appropriately manage a high risk pregnancy by failing to hospitalize the patient for a perinatologist consultation upon obtaining conflicting test results that may have indicated intrauterine growth restriction more than two weeks prior to delivery.
6.	MD-04-1506A	AMB	MARC. A. BAUDER, M.D.	15235	Accept Consent Agreement for Decree of Censure for failing to submit three required urine drug screens and for failure to practice in a group practice pursuant to the Consent Agreement of June 17, 2003.
NO.	**CASE NO.**	**COMPLAINANT v PHYSICIAN**		**LIC. #**	**RESOLUTION**
7.	MD-03-0826A MD-05-0154A	AMB	MARTIN MEYERS, M.D.	27917	Reject signed Consent Agreement and offer a revised Consent Agreement with standard admission language for relapse and habitual intemperance.

By way of block vote, the Board had previously rescinded referral to Formal Hearing and accepted the Proposed Consent Agreement for Voluntary Surrender of License and immediate return of the wallet card and license certificate.

Patrick N. Connell, M.D. pulled this case for discussion.

MOTION: Patrick N. Connell, M.D. moved to have the Board reconsider this case.
SECONDED: Ram R. Krishna, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

Dr. Connell said the physician relapsed with a chemical dependency and has agreed to surrender his license through a Consent Agreement. However, he noted the Consent Agreement is not clear regarding the facts of the relapse and he felt the language and documentation of the Order should be more specific regarding the admission.

Tim B. Hunter, M.D. said the physician could choose to argue an amended Consent Agreement and prompt a tedious process for the Staff. He said the Board already had the physician's Surrender of License agreement and questioned if amending the Order for small details was necessary and the most efficient thing to do.

Christine Cassetta, Legal Counsel said the Arizona Medical Board statutes require a clear admission in the Order and therefore the appropriate language is important in this case.

Dr. Connell said he also believed having a clear admission in the Order would help establish a thorough history for the Board if the physician reapplied at a later date. Sharon B. Megdal, Ph.D. said she believed the Minutes of the Board Meeting maintained an adequate history. Patrick N. Connell, M.D. noted that the Minutes could lose the flavor of the case years after the fact.

MOTION: Sharon B. Megdal, Ph.D. moved to reject the consent and offer a revised agreement with standard admission language for relapse and habitual intemperance.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D, Paul M. Petelin, Sr., M.D. The following Board Member voted against the motion: Tim B. Hunter, M.D.
VOTE: 11-yay, 1-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
8.	MD-05-0088A	C.D.	LAWRENCE C. RUNKE, M.D.	8190	Accept Consent Agreement for Voluntary Surrender of License.
9.	MD-01-0349	AMB	ALAN I. RICHMAN, M.D.	25503	Accept Consent Agreement for Voluntary Surrender of License.

Judith Berman, counsel spoke to ask the board to accept the Consent Agreement that Dr. Richman signed. She said the physician currently is out of state.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
10.	MD-01-0602	C.S.	ZAFAR QURESHI, M.D.	8269	Consent Agreement for Letter of Reprimand for unprofessional conduct in performing a nerve block on the incorrect side of a patient; failing to conduct a thorough physical exam prior to injecting the patient with a prescription medication; failing to maintain adequate records and Probation for two years with 20 hours CME in Medical Record Keeping, Shall receive quarterly chart reviews from Board Staff, Shall have an Office Practice Management Consultant reevaluate his practice within one year of the effective date of the Order.

MOTION: Becky Jordan moved to rescind referral to Formal Hearing and accept the Proposed Consent Agreement for items 5,6,7,8,9, and 10.
SECONDED: Patrick N. Connell, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D, Paul M. Petelin, Sr., M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
Motion Passed.

THURSDAY, FEBRUARY 9, 2006

CALL TO ORDER – 8:00 a.m.

Tim B. Hunter, M.D. called the meeting to order at 8:00 a.m.

ROLL CALL

The following Board Members were present: Patrick N. Connell, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D., Paul M. Petelin, Sr., M.D. The following Board Members arrived later: Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., William R. Martin, III, M.D.

CALL TO THE PUBLIC – 8:00 a.m.

Statements issued during the Call to the Public appear beneath the case referenced.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-05-0689A	AMB	STANFORD C. LEE, M.D.	30685	Draft the Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for prescribing to family members.

Stanford Lee, M.D. was present without counsel.

Maricarmen Martinez summarized the case for the Board. The Arizona Medical Board received notification from a pharmacy technician that Dr. Lee had been prescribing controlled substances to an immediate family member ("FL") over a long period of time. After an Investigative Interview with Dr. Lee, Board's staff determined he was not impaired but that he had prescribed for a patient without establishing an appropriate physician/patient relationship.

Dr. Lee said stopped prescribing for FL prior to receiving notification from the Board. He discovered FL's addiction after taking a course in pain management. Dr. Lee said he did not know he could not prescribe controlled substances to family members, but has now read the Arizona Medical Board Statutes and Rules and is aware of his violation.

Dona Pardo, R.N., Ph.D. led the questioning. Dr. Lee said he meant it only as temporary care for treating elbow pain when he began prescribing to his spouse, but upon relocating to Arizona, he didn't know of any colleagues to refer FL to and FL was refusing to see another physician.

Dr. Lee said that after taking 12 hours of CME in Pain Management dealing with opiates and usage of drugs, he learned FL was addicted and attempted to wean her from the medication. Dr. Lee said said FL is now on the road to recovery and he will not treat family members with controlled substances in the future.

Dr. Pardo said she felt this was an unfortunate situation for the physician and FL. However, although it turned out alright in the end, the doctor did commit unprofessional conduct.

MOTION: Dona Pardo, R.N., Ph.D. moved to find Unprofessional Conduct in violation of A.R.S. § 32-1401(27)(h)- Prescribing or dispensing controlled substances to members of the physician's immediate family.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 10-yay, 0-nay, 0-abstain/recuse, 2-absent
MOTION PASSED.

Dr. Pardo said she feels the physician has learned from this experience and there are mitigating circumstances in this case.

MOTION: Dona Pardo, R.N., Ph.D. moved to Draft the Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for prescribing to family members.
SECONDED: Ram R. Krishna, M.D.

Paul M. Petelin, Sr., M.D. spoke against the motion stating he was in favor of Advisory Letter. Dr. Petelin said the physician seemed to have learned from this case and he doesn't know if disciplinary action would serve any purpose at this point.

Tim B. Hunter, M.D. said as a history, the Board is usually strict in these types of cases but agrees with Dr. Petelin's comments and feels this case is slightly different in that the physician kept medical records on FL's care.

Sharon B. Megdal, Ph.D. spoke in support of the motion for consistency reasons. Dr. Pardo said there was some patient harm in that the patient became addicted.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Becky Jordan, Ram R. Krishna, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D. The following Board Members voted against the motion: Tim B. Hunter, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., Paul M. Petelin, Sr., M.D. The following Board Members were absent: Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D.
VOTE: 6-yay, 4-nay, 0-abstain/recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-04-0351A	AMB	THOMAS F. NORTON, M.D.	7469	Dismissed.

Dona Pardo, R.N., Ph.D. and Lorraine Mackstaller, M.D. recused themselves from the case.

Dr. Norton was present with Counsel James W. Kaucher, Esq.

Gerald Moczynski, M.D., Medical Consultant summarized case. He said the case was opened as result of malpractice settlement involving Dr. Norton. He said it is alleged Dr. Norton negligently performed a left suboccipital craniectomy for vascular decompression on a patient with trigeminal neuralgia. Dr. Norton saw the 51-year old patient on June 23, 1998 for possible surgical intervention for trigeminal neuralgia. Dr. Norton had noted in his consultation that he reviewed an MRI scan of 1991. Dr. Norton performed surgery on July 18, 1998, specifically a suboccipital craniectomy and decompression that resulted in hemorrhage from an occult vascular malformation as it was dissected. Postoperatively, the patient had symptoms of a brain stem injury secondary to coagulation of feeding vessels to the vascular malformation. The Outside Medical Consultant was concerned Dr. Norton relied on a 7 year old MRI scan, but noted that even a new MRI scan might not identify the vascular malformation.

Dr. Norton said he did not believe another scan was indicated because the scan that was on file did not show evidence of a tumor. He said that if a tumor had developed, the patient would have symptoms. Absent those symptoms, there was not a reason to do another scan at the time of surgery. Additionally, he said the technology in 1998 would not have revealed an occult vascular malformation.

William R. Martin, M.D. led the questioning. Dr. Norton said it would be more common to operate on a younger patient rather than an older patient and he considered this 52-year-old patient a "younger patient".

Dr. Martin asked if this incident changed his approach to patients with trigeminal neuralgia. Dr. Norton said the approach has now changed because the technology has changed. Dr. Norton said he has the advantage of being involved with the evolution of trigeminal neuralgia treatment from a neurological standpoint and feels he is well qualified in this area.

Paul M. Petelin, Sr., M.D. said he believed an MRA should have been performed prior to surgery to look for lesions in other parts of the brain that may have evolved over the seven years. He said he believed the physician still would have operated on the patient, but it may have lessened the chances of a neurological event.

Mr. Kaucher, counsel for Dr. Norton, said Dr. Norton has a good record of patient care for his 35 years of practice. He also said it is largely undisputed that an additional scan at that time of the surgery would not have shown the patient's AVM because of where technology was at in 1998.

Dr. Martin said it was unsettling to him that another MRI was not ordered prior to surgery, but he realized his concern in this case was not evidence based. Dr. Martin said the patient's complaints had not changed and there was not a reason for Dr. Norton to order another scan. Dr. Martin said the standard of care is to conduct appropriate imaging prior to surgery and he believes this was done in this case.

Motion: William R. Martin, III, M.D. moved to dismiss the case.
Seconded: Ram R. Krishna, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Paul M. Petelin, Sr., M.D. The following Board Members were recused: Lorraine Mackstaller, M.D., Dona Pardo, R.N., Ph.D. The following Board Members were absent: Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D.
VOTE: 8-yay, 0-nay, 0-abstain, 2-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-04-0318A	T.R.	CHARLES ATKINSON, M.D.	26810	Advisory Letter for a technical error by removing an excessive amount of breast tissue during breast reduction.

Charles Atkinson was present with Counsel James W. Kaucher, Esq.

William Wolf, M.D., Medical Consultant summarized the case for the Board. He said that Dr. Atkinson performed a breast reduction surgery and complication ensued. It was the Outside Medical Consultant's position that Dr. Atkinson's general surgery training did not prepare him for breast reduction surgery. It was also the Outside Medical Consultant's opinion that a superior pedicle breast reduction was the wrong procedure for the patient and an inferior pedicle reduction was the preferred procedure. Dr. Wolf. noted that surgical residencies differ from one another and it is possible a resident could have specific training within the purview of plastic surgery and have become competent during residency.

Dr. Atkinson said the superior pedicle breast reduction procedure is a recognized procedure although not the most common procedure. He said the complications that resulted with this patient could have resulted with either the inferior or superior procedures. He said the fact the complication occurred does not mean he erred in the patient's care. Dr. Atkinson said he is practicing only general surgery at this time and had only provided breast reduction surgeries while in the military because he was qualified to do so and the military assigned him to that type of work.

Paul M. Petelin, Sr., M.D. led the questioning. Dr. Petelin noted Dr. Atkinson had performed about 50 cases of reduction mammoplasty. Dr. Atkinson said that although he is a general surgeon he believes he received the adequate training for reduction mammoplasty, and the chairman of surgery for the department he worked in also considered him to be well trained for the procedure. Dr. Atkinson also said he worked closely with a plastic surgeon while in the military who assisted him on numerous cases and whom he would also refer patients to. He said he offered this patient to see his colleague, but the patient refused. He said the patient also refused a free nipple graft.

Dr. Petelin said he reviewed the pre-operative and post-operative pictures in this case and found that it appeared Dr. Atkinson reduced the patient far below a size she would be comfortable with, and the patient then required a breast augmentation. Dr. Petelin said he found this more concerning than the complication in this case. Dr. Atkinson said he discussed with the patient reducing her to a size B or C, but during surgery he found the patient's breasts were very dense and he had to thin the flaps further that he had planned. Dr. Atkinson said plastic surgeons encounter this often and that is why the size of the breast is not guaranteed post-surgery. Dr. Atkinson said the patient was very happy after the surgery with the results and only became unhappy when the necrosis occurred. He said the patient saw another physician who told her she was treated inappropriately and the patient never returned.

Mr. Kaucher, counsel for Dr. Atkinson said the Board has not sustained any statutory violations in this case and in the discussion for this case there has been no criticism of the actual performance of the surgery.

Dr. Petelin said he did find a problem with the complication from the surgery, but rather that the breast reduction was so small that the patient eventually went on to have breast augmentation. He said he found patient harm in that the patient required additional surgery.

MOTION: Paul M. Petelin, Sr., M.D. moved to issue an Advisory Letter for a technical error by removing an excessive amount of breast tissue during breast reduction.
SECONDED: Ram R. Krishna, M.D.

Douglas D. Lee, M.D. said that although he agrees the patient experienced a known complication of the procedure, it seemed the patient was disturbed that Dr. Atkinson appeared calloused in approaching her issues. Dr. Lee said he felt the patient was more troubled with the Dr. Atkinson's bedside manner rather than the results.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D., Paul M. Petelin, Sr., M.D. The following Board Member abstained: Robert P. Goldfarb, M.D. The following Board Member was not present: Ronnie R. Cox, Ph.D.
VOTE: 10-yay, 0-nay, 1-abstain, 0-recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-03-0978A	F.L.	HENRY H. ROENIGK, M.D.	9492	Dismissed.

Robert P. Goldfarb, M.D. recused himself from the case.

Patient F.L was present and spoke during call to public. The patient alleged that in 1985 when he met Dr. Roenigk, he had a full head of hair, was told two surgeries was all he would need to achieve his desired result. He said the end result was 13 surgeries resulting in huge bald area from the top of his head down to his ear and he now has noticeable scarring. He said he asked Dr. Roenigk to correct the problem because most of the medical specialists he consulted said they could not help him. He also alleged that he has attempted to gain access to his full medical records and pictures for the past six years.

Henry Roenigk, M.D. was present with counsel Mr. Andrew Rosenzweig.

William Wolf, M.D., Medical Consultant summarized the allegations in the case as listed above by patient F.L. He said the Outside Medical Consultant found Dr. Roengik did not offer state of the art techniques to the patient and performed mini scalp reductions, which was not considered to be the standard of care in the 1990's.

William R. Martin, M.D. led the questioning. Dr. Roenigk said mini scalp reductions are still the standard of care and he named two experts who support him. Dr. Roenigk explained that he did small width scalp reductions so he closed the wound without infection and continued to do so in stages. Dr. Martin noted the medical record showed he did not use a scalp expander on this patient. Dr. Roenigk said not everyone agrees that is the standard of care and not everyone uses that technique. Dr. Roenigk addressed the allegation of failure to provide medical records. He said that the additional records and photographs the patient requested were maintained by another facility and he was unable to obtain them for the patient.

Ronnie R. Cox, Ph.D. asked Dr. Roenigk if he educates his patient about the procedure beforehand. Dr. Roenigk said he usually speaks to patient for about 15-20 minutes for the initial consultation. He said patient F.L. was a very knowledgeable patient on the subject of his procedure. Dr. Wolf noted there were about 16 signed consent forms in the patient's medical record.

Mr. Rosenzweig, counsel for Dr. Roenigk said he had obtained opinion statements in support of Dr. Rosenzweig from two expert witnesses who lecture at different places around the country. He said Dr. Roenigk was well within the standard of care for treating this patient.

Dr. Martin said the record showed the patient continued to see Dr. Roenigk for several years, indicating the patient must not have been too dissatisfied with the care he was receiving. He said that based on his review of the case and the discussion with the physician in front of the Board, he found no deviation from the standard of care.

MOTION: William R. Martin, III, M.D. moved to Dismiss the case.
SECONDED: Paul M. Petelin, Sr., M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Ronnie R. Cox, Ph.D., Tim B. Hunter, M.D., Ram R. Krishna, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, R.N., Ph.D, Paul M. Petelin, Sr., M.D. The following Board member voted against the motion: Douglas D. Lee, M.D. The following Board Member was recused: Robert P. Goldfarb, M.D. The following Board Members abstained from voting: Patrick N. Connell, M.D., Becky Jordan, Sharon B. Megdal, Ph.D.
VOTE: 7-yay, 1-nay, 3-abstain, 1-recuse, 0-absent
MOTION PASSED.

ELECTION OF OFFICERS

Tim B. Hunter, M.D. announced the candidates for Board Chair, Board Vice-Chair and Board Secretary. He said that Robert P. Goldfarb, M.D. and William R. Martin, III, M.D. had been nominated for Board Chair, there were no candidates for Vice-Chair and Douglas D. Lee, M.D. and Dona Pardo, R.N., Ph.D. had been nominated for Board Secretary.

MOTION: Ram R. Krishna, M.D. moved to close the nominations.
Seconded: Patrick N. Connell, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

Dr. Hunter said there was a tie vote for Board Chair. The Board agreed that it should be the decision of the two Board Members to decide how the tie would be broken and that whoever was not given the position of Board Chairman would be given the position of Board Vice-Chairman.

William R. Martin, III, M.D. thanked each Board member who supported his nomination and asked that the Board unanimously elect Robert P. Goldfarb, M.D. as Board Chair.

MOTION: William R. Martin, III, M.D. moved to elect Robert P. Goldfarb, M.D. as Board Chair.
SECONDED: Ram R. Krishna, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

Dr. Hunter announced that Robert P. Goldfarb, M.D. had been elected for Board Chair, William R. Martin, III, M.D. would remain as the Board's Vice-Chair and Douglas D. Lee, M.D. would remain as the Board's Secretary.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-03-0190A	AMB	MAX D. LIND, M.D.	4576	Advisory Letter for inappropriate diagnosis treatment and management of migraine headaches and inadequate medical records. The licensee has demonstrated compliance through rehabilitation or remediation that has mitigated the need for disciplinary action.

Paul M. Petelin, M.D. recused himself from the case.
Max Lind, M.D. was present without counsel.

Kelly Sems, M.D., Medical Consultant summarized the case for the Board. The Arizona Medical Board received a complaint from a pharmacist regarding Dr. Max Lind's excessive prescribing of Vicoprofen for his employee. Upon reviewing Dr. Lind's medical records the Medical Consultant found that Dr. Lind did not perform a history and physical for the patient. There was potential harm identified in this case.

Dr. Lind conceded he did not keep adequate medical records on the patient. He said the patient was an employee of his and would have migraine headaches seemingly related to the atmosphere. He said the patient saw a neurologist who recommended pain medications. Dr. Lind said because he did not keep adequate medical records, the patient received more medication than he realized. Dr. Lind said he corrected the problem after the pharmacist called.

Patrick N. Connell, M.D. led the questioning. Dr. Connell noted Dr. Lind acted as the patient's physician for a number of years and yet there was no establishment of diagnosis or findings to show that he was treating the patient for a headache. Dr. Lind said the diagnosis was established by the neurologist the patient went to see and by the patient's symptoms. Dr. Lind said there should have been a consultation in the chart that the Board should have received. Dr. Lind said he has retired from the practice of medicine and had corrected his behavior before retiring.

Dr. Connell said that by the physician's own testimony he admits the medical records were not adequate and did not meet the standard of care.

MOTION: Patrick N. Connell, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401(27)(q) - Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public and A.R.S. §32-1401(27)(e) - Failing or refusing to maintain adequate records on a patient.
SECONDED: Ronnie R. Cox, Ph.D.
VOTE: 10-yay, 0-nay, 1-abstain, 1-recuse, 0-absent
Motion Passed.

Dr. Connell said that based on the physician's testimony he understands he does not meet the standard of care, has corrected his practice and is now retired. Dr. Connell said he did not think this case rose to the level of discipline as the physician's conduct has been admitted and remediated.

MOTION: Patrick N. Connell, M.D. moved to issue an Advisory Letter for inappropriate diagnosis, treatment and management of migraine headaches and inadequate medical records. The licensee has demonstrated compliance through rehabilitation or remediation that has mitigated the need for disciplinary action.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D. The following Board Member was recused: Paul M. Petelin, M.D. The following Board Member abstained: William R. Martin, III, M.D.
VOTE: 10-yay, 0-nay, 1-abstain, 1-recuse, 0-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
6.	MD-05-0214A	AMB	JOHN S. TRUITT, M.D.	21749	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for inappropriately diagnosing recurrence of malignancy and treating the patient with radiation and chemotherapy when lesions were benign.

William R. Martin, III, M.D. filled in as the Board Chair for this case.

John Truitt, M.D. was present with counsel Mr. Heard Smith.

Kelly Sems, M.D., Medical Consultant summarized the case for the Board. The Arizona Medical Board received a confidential complaint regarding a 76-year-old patient of Dr. Truitt's who was diagnosed and treated for breast cancer. Ten years later, the patient had low back pain. Dr. Truitt negligently diagnosed the pain as metastatic pain and treated the patient with chemotherapy and radiation. Dr. Truitt did order further studies on the patient, but did not appropriately interpret the studies.
Dr. Truitt said the patient was treated in 2002. Since that time he has received a Letter of Reprimand from the Board and is now consistent in obtaining tissue diagnosis before treating. He said that, in retrospect, the patient most likely had degenerative change. Dr. Truitt admits

he made a mistake in the way he diagnosed and treated this patient. He did note that although radiation treatment was below the standard of care, the patient's pain was relieved temporarily after treatment. Dr. Truitt said that degenerative disease does get better with radiation therapy, but is below the standard because it is only a temporary cure. Dr. Truitt also said the dose that was administered to the patient for the treatment of pain was low enough to prevent injury of the involved tissues. He said there were no ill effects to the patient. However, Dr. Truitt said he has not and will not treat a patient in this manner again.

Tim. B. Hunter, M.D. led the questioning and noted Dr. Truitt's practice has now been altered to require the patient to have positive tissue proof before treating.

Robert P. Goldfarb, M.D. referred to several MRI scans done on the patient over the period of one year that were all negative for metastatic disease. Dr. Goldfarb noted that the radiologist that reviewed an MRI on the patient believed the patient had degenerative change and that no one else was convinced the patient had metastatic disease except for Dr. Truitt. Dr. Truitt concedes to this and said he should have obtained a biopsy or a second opinion. Dr. Truitt said he has since changed his method of treatment.

Dr. Hunter said he found Dr. Truitt to be forthright in admitting he did not meet standard of care, and he has changed his practice so that this type of error will be prevented in the future.

MOTION: Tim B. Hunter, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. § 32-1401(27)(q) - Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Ram R. Krishna, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
Motion Passed.

Dr. Hunter said that the Board has disciplined physicians in the past for unprofessional conduct although the conduct has been remediated. Dr. Hunter said he felt an Advisory Letter would not be consistent with the Board's past actions.

MOTION: Tim B. Hunter, M.D. moved to Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for inappropriately diagnosing recurrence of malignancy and treating the patient with radiation and chemotherapy when lesions were benign.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D. The following Board Member voted against the motion: Paul M. Petelin, M.D.
VOTE: 11-yay, 1-nay, 0-abstain 0-recuse, 0-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
8.	MD-04-0173A	AMB	SHAHID MALIK, M.D.	31690	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for prescribing to members in his family and failing to maintain adequate patient medical records.

Shahid Malik, M.D. was present without counsel.

Patricia McSorley, Senior Medical Investigator summarized the case for the board. The AMB received a complaint from a pharmacist that Dr. Shahid Malik had prescribed a controlled substance for an immediate family member ("FM"). The prescription was caught by the pharmacy before it was filled and FM did not receive the medication. The pharmacist said Dr. Malik was unprofessional when confronted about the prescription and used profanity and was yelling at the pharmacist. Ms. McSorley also noted that there were 13 other occasions were Dr. Malik did prescribe medications that were originally ordered by other physicians that were non-controlled substances.

Dona Pardo, R.N., Ph.D. led the questioning. Dr. Malik said he prescribed the controlled substance for FM as a one time occasion because FM's physician had retired and FM was in the process of moving to Arizona. He said he admits he did not keep adequate records for this incident. Dr. Malik said he was also not aware that he was in violation of Arizona statutes. Dr. Malik said he disagreed that his conversation with the pharmacist was unprofessional and that he did not use profanity.

Paul M. Petelin, Sr., M.D. noted that the pharmacist vividly described the phone call between he and Dr. Malik as unprofessional in that he said Dr. Malik was yelling and using profanity. The pharmacist also said there two witnesses present during the conversation who can testify to the episode. Dr. Petelin said he found the physician's behavior to be as disturbing as the inappropriate prescription.

Tim B. Hunter, M.D. noted the incident occurred two years previously and has not reoccurred. He said he believes the physician is fully aware of the Statues and this will not occur again.

MOTION: Dona Pardo, R.N., Ph.D. moved to find unprofessional conduct in violation of A.R.S. §32-1401 (27) (h) - Prescribing or dispensing controlled substances to members of the physician's immediate family and A.R.S. §32-1401 (27) (e)- Failing or refusing to maintain adequate records on a patient.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

MOTION: Dona Pardo, R.N., Ph.D. moved to Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for prescribing to members in his family and failing to maintain adequate patient medical records.
SECONDED: Paul M. Petelin, Sr., M.D.

William R. Martin, III, M.D. said he was concerned about the unprofessional behavior Dr. Malik displayed to the pharmacist. Christine Cassetta, Legal Counsel said there is no statutory provision that would allow the Board to punish this type of unprofessional behavior. However, the Board's Physician Health Program can deal with these issues and Dr. Malik is free to contact Staff and inquire about the Program.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, R.N., Ph.D., Paul M. Petelin, Sr., M.D. The following Board Member was absent: Sharon B. Megdal, Ph.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

OTHER BUSINESS

1.	MD-05-0156A	AMB	ASHOK GARG, M.D.	27507	Dismissed.

Mark Nanney, M.D., Chief Medical Consultant summarized the case. The case was brought to attention of the Arizona Medical Board due to an investigation of Dr. Ashok Garg's implantation of a stolen pacemaker that had been purchased on E-bay. The investigative findings did not support the allegation that Dr. Garg knew the pacemaker was stolen. Dr. Nanney said a wide-range quality of care investigation was opened regarding patients R.B. and G.G. Each case was thoroughly investigated and none of the allegations were sustained. Dr. Nanney said there was also an allegation of improper type of pacemaker implantation for patient G.G., in that it was a larger pacemaker than should have been used, but the medical consultant found no actual patient harm or potential patient harm in doing so. After a thorough investigation, Dr. Garg was found to be within the standard of care.

Tim B. Hunter, M.D. commented that the allegation of Dr. Garg being aware that the pacemaker was stolen was not sustained because he was not the purchaser of the pacemaker and it was handed to him by another individual, the pacemaker appeared to be in the proper packaging, and Dr. Garg would have had no indication the pacemaker had been purchased inappropriately. Dr. Garg was not responsible for purchasing the pacemaker.

MOTION: Ram R. Krishna, M.D. moved to dismiss the case.
SECONDED: Douglas D. Lee, M.D.
VOTE: 10-yay, 0-nay, 1-abstain/recuse, 1-absent
MOTION PASSED.

Dr. Hunter noted that this case had been a long complicated case. He said the case was initially brought to the Board as a recommendation for Summary Action. Dr. Hunter said that the witnesses and materials reviewed by the Board has led to dismissal of this case. Dr. Hunter noted that the Minutes from the February 25, 2005 Summary Action Meeting where the Board previously discussed the case, should be linked to the Minutes from the February 8-9, 2006 Meeting. Dr. Hunter said it was important that the record reflect that the Board has found Dr. Garg's practice to be within the standard of care.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
9.	MD-04-1504A	MICA	MAZEN H. KHAYATA, M.D.	27507	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to properly evaluate the patient and review critical imaging studies before embarking on a surgical approach.

Robert P. Goldfarb, M.D. said he knows the Outside Medical Consultant who reviewed this case but it will not affect his ability to adjudicate the case.

Mazen H. Khayata, M.D. was present with counsel, Mr. Paul Giancola.

William Wolf, M.D., Medical Consultant summarized the case for the Board. The case came to the attention of the Arizona Medical Board as a result of a medical malpractice settlement. An eighty-eight year-old patient presented with possible head trauma. A CT scan was incorrectly read by the radiologist as epidural with mass effect. Dr. Khayata was consulted and recommended surgery based upon the CT reading as reported by the radiologist. He did an exam of the patient and found no neurological findings. The Outside Medical Consultant states this should have been a red flag for two reasons. First, epidural hematomas are rare in this age group and absence of neurological findings is also unusual. The patient was anticoagulated at baseline so preoperative correction was ordered by another physician, Dr. Aguiar. The Outside Medical Consultant found a deviation and patient harm in that Dr. Khayata should have performed a history and physical for the patient and personally reviewed the scan. Instead, he ordered fresh frozen plasma prior to reviewing the scan and the patient went into congestive heart failure from fluid overload.

Dr. Khayata said when the patient presented to the hospital he performed an exam on the patient that was normal. He said he was told the patient had CT evidence of an epidural hematoma. Dr. Khayata said his plan for her was possible surgery, but noted he first needed to

correct the patient's prothrombin time as it was elevated and was in the 20 range. Dr. Khayata said he then went to view the CT scan for himself and discovered it was totally normal. However, he said when he returned to follow up on the patient, the hospitalist had already ordered fresh frozen plasma for the patient who had received six (6) units of fresh frozen plasma, and was in fluid overload.

Robert P. Goldfarb, M.D. led the questioning. Dr. Goldfarb said it was below the standard of care that Dr. Khayata had not seen the CT scan at the time he ordered a craniotomy for the patient. Dr. Goldfarb said it did not appear the patient was in immediate danger of herniating. Dr. Goldfarb said that Dr. Khayata's decision to perform surgery resulted in a number of orders written to prepare the patient for surgery, including the 6 units of fresh frozen plasma. Dr. Goldfarb also noted Dr. Khayata viewed the CT scan a few hours after ordering the surgery. Dr. Goldfarb found that after Dr. Khayata viewed the CT scan and realized the patient did not need surgery, he tried to get pulmonary involved to help the patient. Dr. Khayata contended the internist wrote the order for fresh frozen plasma and did not speak to him before doing so.

The Arizona Medical Board Members took some time to view the CT films during the Board Meeting and concluded they did not see any evidence for an intracranial bleed.

Tim B. Hunter, M.D. noted it was egregious to administer six units of fresh frozen plasma within about two hours, as the standard of care would be to administer that amount of fluid over a period of about three days.

Dr. Khayata admitted he erred in failing to review the CT scan first. However, he contended he did not order the six units of fresh frozen plasma as he is fully aware that practice would be below the standard of care.

Dona Pardo, R.N., Ph.D. referred to a nursing note in the medical record that showed Dr. Khayata told the nurses to give the patient fresh frozen plasma (FFP). Dr. Khayata said he was unaware the FFP would be administered inappropriately.

Mr. Giancola, counsel for Dr. Khayata summarized their position by saying, Dr. Khayata sees symptoms of intracranial pressure in the patient, makes a recommendation for surgery, goes to read the CT scan and returns to find the intern inappropriately ordered 6 units of fresh frozen plasma and patient was in fluid overload. Mr. Giancola also said it was appropriate for Dr. Khayata to schedule a surgery because it would be easier to cancel a surgery, if it is found it is not needed, then to schedule an emergency surgery.

Dr. Goldfarb said the major problem in this case was that the patient was misdiagnosed. Dr. Goldfarb said he found unprofessional conduct in this case in that the patient was infused at a fast rate all as a result of Respondent ordering an unnecessary surgery. Dr. Goldfarb said that even though the patient died, he would only sustain the statute violation of A.R.S. §32-1401 (27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public. Dr. Goldfarb said the reason he did chose to include a statute violation of A.R.S. §32-1401 (27) (ll)- (Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient) was because he does not know the other physician's full participation in this case, but he can specifically cite A.R.S. §32-1401 (27) (q) as it relates to Dr. Khayata's care.

MOTION: Robert P. Goldfarb, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. § 32-1401(27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Ram R. Krishna, M.D.
VOTE: 10-yay, 0-nay, 0-abstain/recuse, 2-absent
MOTION PASSED.

MOTION: Robert P. Goldfarb, M.D. moved to Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to properly evaluate the patient and review critical imaging studies before embarking on a surgical approach.
SECONDED: Paul M. Petelin, Sr., M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, R.N., Ph.D, Paul M. Petelin, Sr., M.D. The following Board Members were absent: Sharon B. Megdal, Ph.D., Becky Jordan
VOTE: 10-yay, 0-nay, 0-abstain/recuse, 2-absent
MOTION PASSED.

The Board referred this matter back to Staff for an investigation of the radiologist involved in this case.

Meeting adjourned at 5:25 p.m.

Timothy C. Miller, J.D., Executive Director